Understanding the Processes Involved in Implementing an Improving Access to Psychological Therapies Service: An Exploratory Study that Investigates Practitioner and Client Experience Regarding its Effect on Patient Pathways, Service Design and Overall Outcomes

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor of Philosophy by Scott Alan Steen

December 2015

Declaration by Candidate

I hereby declare that this thesis is my own work and effort and that it has not been submitted elsewhere for any award. Where other sources of information have been used, they have been acknowledged.

Signature: ……..

Date: ……..

Acknowledgements

Throughout this research project, there have been a number of individuals who have supported, advised and encouraged me that I would like to extend my gratitude. I am forever grateful to each and everyone of you, and offer my sincerest thanks and admiration.

Firstly, I would like to thank those who participated in this project and made this study possible. Equally, to those services and professionals who offered me their time and input during recruitment and data collection, I am indebted to all of you for your kind help, understanding and advice.

I would especially like to thank my academic supervisors, Professor Patrick Pietroni and Professor Michael Thomas for their remarkable skills, expertise, enthusiasm and intrigue. Their patience, dedication and understanding have been absolutely essential throughout this process and I really cannot thank them enough. Similarly, I would like to thank Professor Elizabeth Mason-Whitehead whose kind-hearted nature, knowledge and guidance have helped further my understanding and approach towards the research process.

I also give thanks to my other colleagues at the Centre for Psychological Therapies in Primary Care. Each member has generously offered me their time, support and guidance, but most importantly, their humour and friendship.

To my family and friends, I extend special thanks for their patience and understanding throughout this whole process. In particular, I would like to thank my mum and my sister who have been an absolute blessing and a constant source of love, support and inspiration.

Understanding the Processes Involved in Implementing an Improving Access to Psychological Therapies Service: An Exploratory Study that Investigates Practitioner and Client Experience Regarding its Effect on Patient Pathways, Service Design and Overall Outcomes

Scott Alan Steen

Abstract

The English Improving Access to Psychological Therapies (IAPT) programme is a government-funded initiative that aims to provide timely and equitable access to evidence-based psychotherapeutic interventions, within a primary care setting. Despite the many achievements of the programme, there are several issues regarding research to clinical gaps, as well as a high rate of variation between sites concerning outcomes and attrition. This thesis explores the implementation process of the IAPT delivery model to understand which factors are influential in the successful uptake and integration of evidence-based psychotherapeutic interventions.

The aims of this thesis are:

- To explore, identify and analyse the implementation process involved in establishing and delivering an IAPT service.
- To uncover the factors that either facilitate or impede its development to provide a more in-depth and detailed account of the implementation and operation of services.
- To develop an understanding regarding the applicability of evidence-based practice and the IAPT delivery model in a clinical setting, for the provision of psychological therapies.

I conducted a series of semi-structured interviews with practitioners delivering and implementing services, across seven sites, and clients, across three sites. The design and analysis followed an Interpretative Phenomenological Analysis, focusing on personal meaning and sense-making processes. The objective of the interview was to understand the implementation process regarding the IAPT delivery model, exploring how this influences personal experiences and client engagement. Additionally, participant narrative was set in context using open-access data collected and published by the programme.

The analysis generated three master themes for practitioners delivering and implementing services including: ‘A Call to Action’ describing how participants regarded this process as a genuine opportunity to make a real impact in mental healthcare; ‘Contextual Influences on Service Operation’ which explores the activities in becoming a locally determined, adaptable and relevant service; and a ‘Focus on Relationships’ outlining the relational and collaborative work involved during implementation.

For the client group, three master themes were generated including: ‘A Personal Journey: From Discovery to Advocacy’ illustrating the changing experiences involved during service access and engagement; ‘Perception of Self’ which portrays how individuals made sense of their engagement by judging what it meant to them;

and ‘Outside Factors’ which explores the role of others and the physical journey made in getting to services.

The analysis suggested that both groups made sense of their experiences in complex and varied ways. Heavily influencing the implementation of the IAPT delivery model is the over-arching need to boost throughput and quantity, possibly at a cost of quality. Additionally, it is argued that the use of routine outcome monitoring in services is useful for reflecting on the implementation process and engaging clients. The key to successful implementation appears to be about achieving integration, requiring a whole-systems based approach that considers the mediating pathways into and out of services. In light of the findings and literature, the thesis proposes several recommendations for future practice and further research.

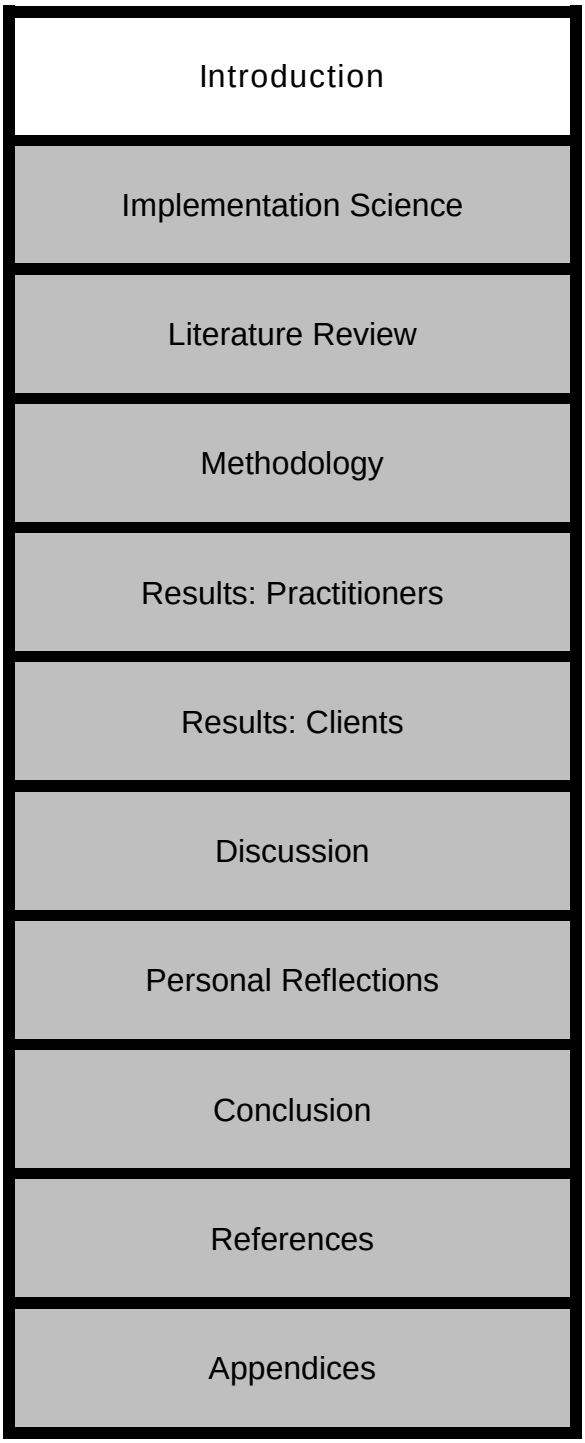
Key Words:
IAPT; Improving Access to Psychological Therapies; Psychotherapy; Depression; Anxiety; Common Mental Health Problems; Implementation; Service Design; Organisational Dynamics

Table of Contents

List of Figures and Tables

List of Abbreviations

BACP	British Association for Counselling and Psychotherapy
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHP	Common Mental Health Problem
CORE-OM	Clinical Outcomes in Routine Evaluation-Outcome Measure
DH	Department of Health
EBPI	Evidence-Based Psychological Intervention
FT	Foundation Trust
GAD-7	Generalised Anxiety Disorder 7-item Scale
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
ICD-10	International Classification of Diseases-10th Revision
IPA	Interpretative Phenomenological Analysis
KPI	Key Performance Indicator
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPT	Normalisation Process Theory
PbR	Payment by Results
PHQ-9	Patient Health Questionnaire-9
PWP	Psychological Wellbeing Practitioner
RCP	Royal College of Psychiatrists
RCT	Randomised Controlled Trial
ROM	Routine Outcome Monitoring
WHO	World Health Organization
WSAS	Work and Social Adjustment Scale


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Personal Reflections
Conclusion
References
Appendices

1 Introduction

1.1 Overview

In this chapter, I begin with a general overview of the subject and focus of this thesis, which includes a brief discussion on the implementation of the Improving Access to Psychological Therapies (IAPT) programme. It will form the basis and rationale for my research project that will then lead on to a review of the literature and exploration of key concepts in the following chapters.

1.2 Terminology

The term Common Mental Health Problems (CMHPs) includes conditions such as depression and a range anxiety disorders (National Institute for Health and Care Excellence (NICE), 2011a). The validity and reliability of these diagnostic categories for defining mentally ill health can be a source of dispute, especially concerning the substantial overlap shared between classifications (Bentall, 2004; Dowrick, 2004; Guy, Loewenthal, Thomas & Stephenson, 2012; Mollon, 2009; Szasz, 1960). However, given its wide use within mental health services, for which the scope of this thesis is concerned, this terminology was deemed acceptable.

Mental healthcare is home to an eclectic mix of various schools of theories and practices, each with their own preferred terminology. These terms are often a source of debate, loaded with meaning and can be problematic dependent on the understanding of mental health. The term ‘client’ is used as it represents a neutral term, with evidence suggesting its acceptability among various health and social care professionals, in common with those using services (Dickens & Picchioni, 2012; Simmons, Hawley, Gale & Sivakumaran, 2010). Similarly, other terms are used interchangeably such as ‘treatment’, ‘intervention’ and ‘therapy’ to align with the terminology of the research evidence evaluated herein.

1.3 The Improving Access to Psychological Therapies Programme

The IAPT programme is a government-funded initiative that seeks to enhance access to Evidence-Based Psychotherapeutic Interventions (EBPIs) within primary care throughout England (Department of Health (DH), 2011a). It was initially conceived to treat adults of working age for a range of mild-to-moderate CMHPs, including depression and a group of anxiety disorders. 'Mild' and 'moderate' are clinical terms that are used to define the severity of an individual's condition, reflecting the onset, chronicity and frequency of symptoms associated with each illness category. Subsequently, the programme has since expanded its remit to provide services for Severe Mental Illness, Medically Unexplained Symptoms, Long-Term Physical Conditions, and a specialist Children and Young People's service (DH, 2011a).

Its inception is grounded on an economic argument that claims its costs are, in effect, recovered through a return on welfare and lost tax receipts, as well as savings in other health and social care sectors (Layard et al., 2006; Layard, Clark, Knapp & Mayraz, 2007). These developments are also consistent with the broader arguments for social justice of providing timely and equitable access to effective interventions for particular health conditions. It has since gone on to receive unprecedented levels of funding, forever changing the landscape of psychotherapeutic provision, both within and beyond the healthcare sector. Significantly, it represents one of the biggest shifts in policy since the closure of the old mental asylums throughout the last century (DH, 2011a; Clark, 2011; Gilburt, Peck, Ashton, Edwards & Naylor, 2014).

It is a specialist service that is still relatively new in the field of mental healthcare. Driven by a centralised and systematic framework, it has successfully trained a new and existing workforce into delivering EBPIs, with the primary aim to substantially reduce waiting times and boost treatment accessibility (Clark, 2011; IAPT, 2011a). McHugh and Barlow (2010) consider its delivery model and means of implementation as being a world leader in the provision of psychotherapeutic interventions. Its application combines top-level leadership, evidence-based treatments, outcome monitoring and ongoing service refinement. Additionally, the

IAPT Implementation Plan (DH, 2008) provides a framework for all services to use, but importantly allows considerable scope for local determination.

1.3.1 The Implementation and Dissemination of IAPT Services

The efficient use of research evidence within policy implementation can help decision makers ensure the "judicious application of best current knowledge" (Sackett et al., 1996, p.71). However, there are several challenges to reaching this ideal (Black, 2001; Newnham & Page, 2010; Norcross, Beutler & Levant, 2006). Translating the research evidence into a local area context can be difficult due to the complexity of health demands and influences on communities (Black, 2008; Marmot et al., 2010). Likewise, translational gaps in effectiveness have been found to exist between the research setting and clinical practice in the delivery of psychological therapies (Proctor et al., 2009). Understanding and evaluating the implementation process is important in assisting the successful application of national healthcare innovations into local area settings (Eccles et al., 2009; McHugh & Barlow, 2010). The IAPT programme represents a significant step in enhancing treatment fidelity to psychotherapeutic provision, through its use of guidelines, training and supervision techniques, and tool standardisation (McHugh & Barlow, 2010). Notwithstanding, there are some who criticise the IAPT programme for adopting a narrow, reductionist approach, born out of a biomedical understanding of mental healthcare (Guy et al., 2012; Marziller & Hall, 2009; Pietroni et al., 2012; Rizq, 2011, 2012a; Williams, 2015). Similarly, the programme reports high levels of attrition, dropout, and wide variability regarding its access and recovery rates (Glover, Webb & Evison, 2010; Griffiths & Steen, 2013a; HSCIC, 2014a, 2014b; Richards & Borglin, 2011; RCP, 2013), underlining the implementation process as being a crucial stage for understanding these patterns.

The process of implementation in mental healthcare is more than just a technical endeavour of disseminating knowledge and training practitioners (Grimshaw, Eccles, Lavis, Hill & Squires, 2012; Proctor et al., 2009; May et al., 2009). In reality, the context of a service can greatly influence the social, multi-faceted and dynamic processes involved during these stages. Each new parameter of an innovation requires taking into account individual attitudes, expertise, social and cultural norms,

relational working and budgetary constraints (Damschroder et al., 2009; May et al., 2009).

1.3.2 Purpose Statement

There is a paucity of research evidence between what is known to be effective in research trials to what is then delivered in clinical practice (Grimshaw et al., 2012; Proctor et al., 2009). Understanding and evaluating the implementation of complex interventions in a clinical setting is an important issue for policy-makers, commissioners and healthcare managers alike (May et al., 2009). Accordingly, the purpose of this research project is to explore and report on the implementation process between several IAPT services. Studies have found that investigating the implementation process helps to clarify what commissioners, managers and clients need from academics, improving the communication and translation of research evidence into clinical practice (Grimshaw et al., 2012; Evans, Snooks, Howson & Davies, 2013). Understanding the implementation process is increasingly becoming recognised as an important endeavour to ensure the successful translation of effective treatments (Eccles et al., 2009; McHugh & Barlow, 2012). Drawing on the principles of implementation research, the model for investigation will structure itself towards context, process and outcomes of a service. Therefore, understanding the programme's conceptual basis, its current outcomes, and any evidence reporting on workforce and client experience is critical to this process.

1.3.3 Plan of the Thesis

This thesis comprises of two related studies exploring the implementation process regarding the IAPT delivery model. The first involves conducting a series of semi-structured interviews with practitioners delivering and implementing services. It investigates how each participant experiences and makes sense of their decision-making during this process. The second study involves interviewing those who have engaged with an IAPT service to understand how the delivery model influences their experiences. Overall, this thesis is primarily concerned with understanding the dynamics of the implementation process, including how the IAPT delivery model, in

respect to its structure, conceptual basis and philosophical underpinnings, influences its development, outcomes and engagement.

1.3.4 Structure of the Thesis

This chapter presents a background and overview on the scope and subject of the thesis. In the following chapters, I build upon on this by presenting and discussing the relevant concepts and literature to develop a backdrop for the research findings. Although both studies involve two different participant groups, they share the same broad focus and objective, use the same theoretical framework, and collect data using similar techniques. In brief, the following chapters will discuss and synthesise the principal research findings in light of the relevant literature.

Chapter two introduces and discusses the topic of implementation science, including its relevance for contemporary mental health settings. Increasingly, it is being recognised that the translation of research findings into clinical practice represents a gap regarding the effectiveness of treatments. What's more, given the complex and varied nature of mental healthcare, this difference is especially pronounced. The chapter draws upon leading theories and concepts around implementation science, before identifying which frameworks are useful for the scope and focus of this thesis.

Chapter three presents a synthesis of the literature on the IAPT programme, including its ongoing implementation. The chapter reviews and critiques evidence relating to the IAPT delivery model, its conceptual basis, the current emphasis on session-to-session outcome monitoring, and finally any research reporting on practitioner and client experience. At this point, I review how these factors impact on implementation regarding the IAPT delivery model, while also considering how this both influences and is influenced by individual experience. The chapter will identify any disagreements or gaps within the literature that will ultimately determine the chosen methodology and research focus.

Chapter four considers and evaluates the research design and methodology for both studies conducted. It begins by presenting the research aims, objectives and principal research questions, followed by a discussion on the types of methodological inquiry

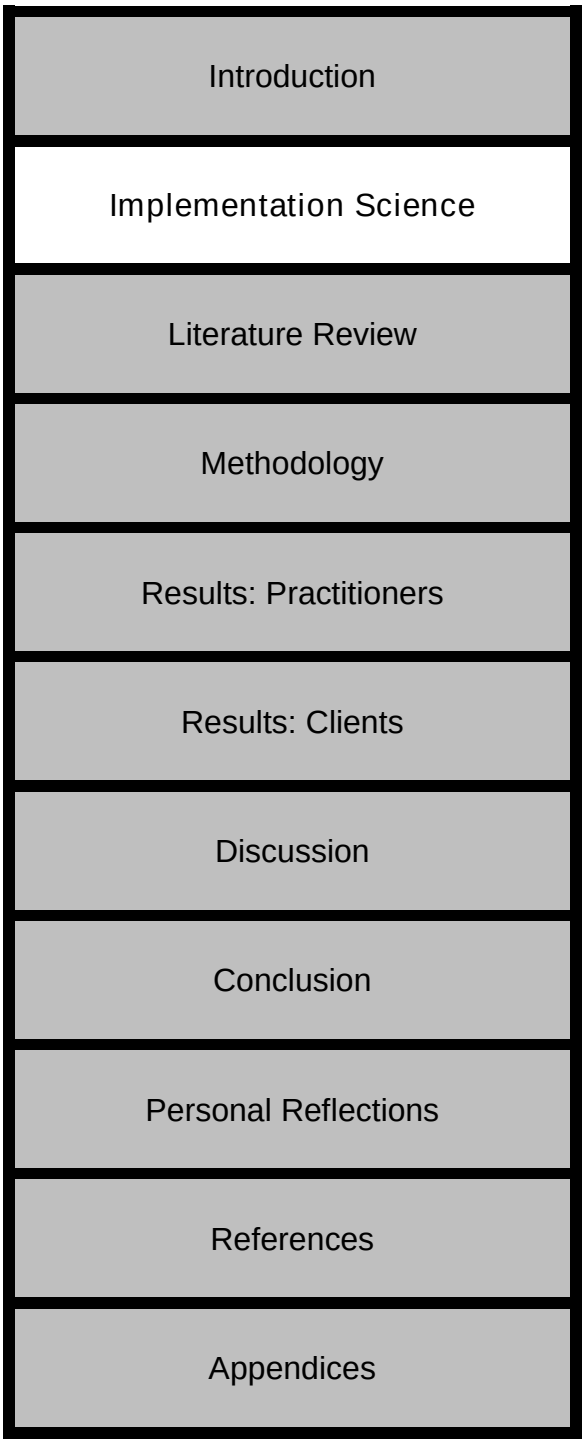
that is best suited to reach these goals. I then explore the potential benefits of embracing a social constructionist epistemological stance for researching the experiences related to the implementation process of the IAPT delivery model. Upon reviewing several other qualitative analysis techniques, this chapter then argues that an Interpretative Phenomenological Analysis is best suited to achieve the research aims. Subsequently, I discuss how the schedule for the semi-structured interviews was constructed and developed, using the conceptual frameworks of the Patient Pathway and the Normalisation Process Theory. At this point, each study involving different participant groups is discussed separately, exploring the important aspects related to each group, including ethical considerations, recruitment and conducting of the interview. Accordingly, the chapter describes the procedure for analysis and improving the trustworthiness of the data. As a whole, the chapter explores how the use of qualitative, semi-structured interview techniques with key stakeholders, through the application of a rigorous, Interpretative Phenomenological Analysis, can help to understand the implementation process.

In chapters five and six, I present the findings and analysis from each participant group; those who are delivering and implementing services, as well as those who have engaged with services. The narratives are contextualised using freely available, open-access data published by the IAPT programme, as well as other public agencies. A series of master and subordinate themes encapsulates the findings, with each theme providing a list of extracts to help ground the data and analysis in the participants' own words. Each theme is introduced and summarised throughout to assist the reader. Additionally, given the interrelatedness of the data, the themes are presented as a diagram to aid understanding.

Chapter seven discusses the analysis of each group, combining the findings of both perspectives, while setting them in context with other literature. Sections of the chapter are broken down to reflect the dynamic, nonlinear and relational processes involved during implementation. Topics include: the impact of adjusting to change, incorporating high-volume throughput, creating a locally relevant service, enhancing service effectiveness, making use of reflective practice, and finally arguing for whole-systems thinking. The chapter also considers any limitations that likely have a bearing on the research findings and conclusions.

Chapter eight concludes with a summary of the main research findings from both studies in light of the relevant literature, identifying the main contributions to new knowledge. Accordingly, the chapter directly addresses the research questions set out in the methodology chapter. Finally, several recommendations are proposed which highlight the implications for services and possible avenues for further research.

In chapter nine I provide a discussion and personal reflective piece on my experiences in undertaking this research project. I offer both broad and specific instances that I consider having had an impact on this thesis and its completion. Specifically, I draw upon each experience as a tool for learning, self-development and growth.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

2 Implementation Science

"*In theory, there is no difference between theory and practice. But in practice, there is."*

Yogi Berra (n.d.) as cited in Wiley (2012, p.3)

2.1 Overview

The process of implementation concerning the Improving Access to Psychological Therapies (IAPT) delivery model and the experiences associated with it will form the focus of this thesis. Firstly, I will present, review and critique, in brief, a general overview of implementation science, including its rationale, concepts and application to mental healthcare. Subsequently, this will help focus and structure the literature review relating to the IAPT programme's implementation and reveal any gaps in knowledge worthy of investigation.

2.2 The move towards Evidence-Based Practice

The emphasis on evidence-based practice within the field of medicine has a lengthy history, long predating its application in clinical psychology (Spring, 2007). As a concept, it requires that clinical decision-making about an intervention is justifiable on the grounds of its demonstrable effectiveness and relevance for patients. As Sackett et al. (1996), a pioneer in evidence-based practice describes:

> Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence for systematic research (p.71)

What constitutes best available clinical evidence is formulated through observation, theory and experimentation. Consequently, this approach attempts to codify knowledge and recommend interventions for particular conditions, integrating it with the needs of the population and present context. Research is regularly updated to

validate and refine interventions, providing ever more accurate, effective and safer treatments. It is constituted of three parts including research evidence, clinical expertise and patient values/preferences (Spring, 2007). It is considered best practice, particularly in a resource-limited healthcare system, such as the National Health Service (NHS) (National Institute for Health and Care Excellence (NICE), 2011a). The commitment towards its use ensures equitable access to contemporary and effective treatments, meaning those typically in most need can benefit. Be that as it may, within the delivery of psychotherapy, determining what constitutes best available evidence remains a source of debate (Guy et al., 2012; Mollon, 2009; Shafran et al., 2009; Westen, Novotny & Thompson-Brenner, 2004; Williams, 2015). Specifically, this is due to the multitude of factors that can influence the course of therapy, reducing the validity of attributing any observed change solely to the intervention used (McLeod, 2013; Moloney, 2013).

2.3 The Research-Clinical Gap

One of the most critical issues concerning the provision of mental healthcare is the research-clinical gap. This gap describes the sharp contrast in reduced treatment efficacy from highly controlled and academic settings, into routine clinical practice (Proctor et al., 2009). In 2001, the US Institute of Medicine described this as “not just a gap, but a chasm” (p.1). Therefore, this is a prominent concern as it wastes resources invested in research, leaving clients to engage with ineffective, non-relevant and potentially harmful interventions.

One way of determining an intervention’s effectiveness is with the use of and preference for controlled study methodologies, including the Randomised Controlled Trial (RCT). These facilitate empirical evaluation by manipulating certain parameters and holding others constant, to evaluate treatment effectiveness, while excluding possible confounding variables and allowing for trial replicability (Robson, 2011). Although a useful approach, several issues exist about their limited relevance in a clinical setting due to their defining characteristics.

These concerns relate to the selection process for recruitment that can involve a high rate of participant exclusion (40-70%) (Westen et al., 2004), greater client

motivation, as demonstrated by an active response to advertising (Holmes, 2002), emphasis on discrete conditions, despite the reportedly high rate of comorbidity (Westen et al., 2004; Kessler et al., 2005; McManus et al., 2009) and disputed use of diagnostic labelling in this area (Bentall, 2004; Guy et al., 2012; Mollon, 2009; Szasz, 1960). Thus, there are concerns that research participants may not be representative of those regularly attending clinical practices. Other issues include a contrast in treatment delivery, which in research tends to be well resourced and delivered by experts, who are closely monitored using treatment manuals, outcome monitoring and supervisory practices (Guy et al., 2012; McHugh & Barlow, 2010; Mollon, 2009). Likewise, measuring the quality of therapy in any setting is still a debated and an uncertain endeavour (Barkham, Stiles, Connell & Mellor-Clark, 2012; Guy et al., 2012). What's more, further misconstruing the effectiveness of an intervention includes the allegiance effect and publication bias, which favours positive findings over negative ones (Munder et al., 2013). Therefore, drawing on evidence that benefits interventions which define conditions and outcomes in terms of diagnosis and symptom reduction, and are verified using controlled methodologies, is likely an unsuitable approach.

Beyond the research setting, there are significant organisational and system barriers that are influential in the clinical delivery of psychotherapy (McHugh & Barlow, 2012). Some contend that the therapeutic relationship plays a highly influential role and that the treatment modality is not the sole contributor to effecting change (Budd & Hughes, 2009; Guy et al., 2012; Mollon, 2009; Moloney, 2013). There is evidence to suggest that across all types of psychotherapeutic modality, each one will tend to produce equivalent outcomes in terms of their effectiveness (Budd & Hughes, 2009; Duncan, Miller, Wampold & Hubble, 2010; Stiles, Barkham, Mellor-Clark & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006). Often referred to as the 'Dodo Bird Verdict', the equivalence in outcomes suggests that it is inappropriate to treat a type of therapy and diagnosis as though they are variables in an experimental design (Budd & Hughes, 2009). Instead, the number of confounding variables in therapy does not lend itself to isolating the effects of specific interventions, thus reducing the appropriateness for this approach in determining the effectiveness of psychotherapy.

Inadequate financing of services as a result of weak institutional and government support is a problem for the dissemination and sustainability of an intervention (McHugh & Barlow, 2010; Seward & Clark, 2010). Moreover, limited access to information and materials by practitioners can also present a problem (Grimshaw et al., 2012; Gyani, Pumphrey, Parker, Shafran & Rose, 2012; Proctor et al., 2009). From the client's perspective, a lack of public awareness and perceived stigma around accessing mental health services can be an issue, with many preferring to deal with problems on their own (Anderson & Brownlie, 2011; Evans-Lacko, Henderson & Thornicroft, 2013; McManus et al., 2009; Mind, 2013). One area of concern is the observed difference in session brevity and dosage of therapy between a research and clinical setting, highlighting shortfalls in provision within clinical practice (HSCIC, 2014a, 2014b; Royal College of Psychiatrists (RCP), 2013). Moreover, national audit data reports that for seven high-intensity psychotherapeutic interventions, including three evidence-based recommended therapies, more than 30% of practitioners are delivering them without any formal training (n=860) (RCP, 2013), again sparking concern over treatment delivery in clinical practice. What's more, practitioners must account for client choice, lifestyle and a potentially poor comprehension regarding mental health.

There have been plenty of responses regarding these concerns. The main response refers to evidence about these kinds of trial methodologies that can and do include a range of participants, for a range of conditions, including comorbidities (Shafran et al., 2009). Similarly, evidence suggests adherence to modality-specific therapy can improve outcomes, suggesting a definite treatment effect (Shafran et al., 2009). McHugh and Barlow (2012) argue against the concept that interventions developed in these trials are rigid and inflexible, highlighting the process of implementation as being the most impactful:

> Failures to achieve comparable outcomes of [Evidence-Based Psychotherapeutic Interventions] EBPIs in service provision settings may be attributable to failed implementation, not necessarily a failure of the intervention (p.5)

One effort has been to emulate the research setting from which the interventions emerge, including a substantial increase in the resource, strong government support, formalised training and supervisory practices, compulsory outcome monitoring, and the use of guidelines to boost treatment fidelity (Clark, 2011; McHugh & Barlow, 2010; Seward & Clark, 2010). How a service enhances treatment fidelity, while also being mindful of the need for local modification remains a challenge for the IAPT programme and implementation of services.

2.4 The Socio-Demographics of Mental Health

The Marmot Review Fair Society, Healthy Lives (Marmot et al., 2010) is an independent report, which identifies the best evidence-based strategies to address health inequalities in England. It is part of a broader approach to identifying the social determinants of health and wellbeing. In their review it states:

> The Commission on Social Determinants of Health (2008) concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.
>
> These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit. (p.3)

This extract helps to highlight the complexity of factors that can influence the wellbeing of an individual. It is also useful to help illustrate the various risks that can lead to Common Mental Health Problems (CMHPs) developing for individuals living in certain areas. As each community is impacted by a unique set of circumstances, so too are the health challenges of these areas. Consequently, this requires a localised and flexible approach to implementing any healthcare innovation. The approach

must be balanced with ensuring fidelity towards the chosen therapeutic model, as regulated by clinical guidance (Proctor et al., 2009; Schoenwald et al., 2011); itself determined by evidence-based practice. Thus, health inequalities will be reduced if every client has equitable access to the same contemporary EBPIs (Cavanagh, 2014; Layard et al., 2012). However, this remains a primary challenge for commissioners and managers implementing a healthcare approach, who must also work within budgetary constraints and an evolving political context.

2.5 A New and Emerging Field

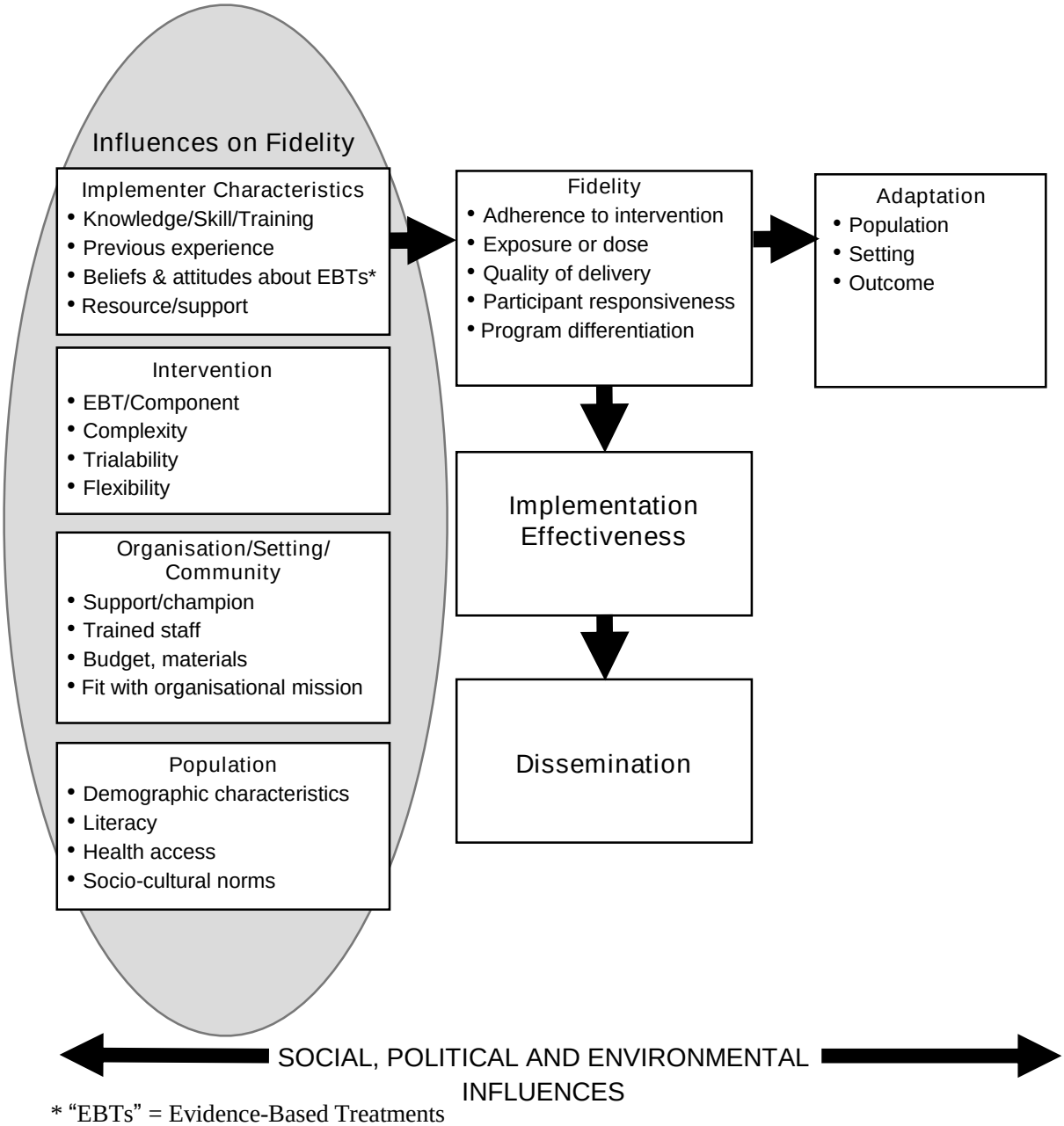
Implementation science is the use of scientific method and inquiry to assess and promote the uptake of evidence-based treatments and practices into a real-world setting (Eccles et al., 2009). As a new and emerging field, there are many varying definitions of what constitutes the purpose and objective of implementation research (Schoenwald, McHugh & Barlow, 2012; Proctor et al., 2009). The most practical definition can be surmised as testing the validity and sustainability of specific interventions within a clinical setting (Schoenwald et al., 2012). It specifically explores the implementation process through a variety of means, in the hopes of translating what is known to be effective in a research environment, into what is then delivered in the clinical setting (Proctor et al., 2009). Notably, the implementation process represents a series of dynamic and nonlinear processes used in assimilating evidence into an organisation and local area context for a given population, with many factors impacting on treatment fidelity (Figure 1) (Allen, Linnan & Emmons, 2012). The focus for implementation research ranges from studies that target implementers (e.g. managers, policy makers, commissioners) to those that target end-users (e.g. clients, carers). Accordingly, it is important to consider and evaluate the conceptual basis for the innovation, its current treatment outcomes, service design and clinical pathways, together with the experiences of key stakeholders in the process.

Historically, government agencies have been at the forefront of evidence-based practice; however, the methods to implement these are not always well developed (Brownson, Colditz & Proctor, 2012). Nevertheless, there is growing interest in finding ways to operationalise the provision of standardised treatments, with this

running parallel to the commitment and integration of evidence-based practice. Over the years, the evidence for demonstrating the effectiveness of individual psychological interventions has blossomed (Hofmann, Asnaani, Vonk, Sawyer & Fang, 2012; Hofman, 2013; McLeod, 2013; Miller, Hubble, Chow & Seidel, 2014; NICE, 2011a). However, the techniques for translating these into a routine clinical practice have lagged behind (Hofmann, 2013; Miller et al., 2014; Proctor et al., 2009). Thus, the stage at implementation is of particular interest in research for better understanding the factors that either facilitate or hinder treatment implementation and its efficacy in a real-world setting.

Implementation science is a growing area of interest in mental healthcare (Gunn et al., 2010; McGorry, 2013; Proctor et al., 2009) with applications already applied to research involving the IAPT programme (Knowles et al., 2013; Richards et al., 2012). The promise of implementation research has been to advance and accelerate the effectiveness of clinical interventions through the development of robust and applicable service strategies (Damschroder et al., 2009; May & Finch, 2009; Nilsen, 2015; Proctor et al., 2009). Therefore, it is an important area for researchers, health professionals, managers, policy-makers, and clients to consider (May et al., 2009; McHugh & Barlow, 2012).

Figure 1: Factors Influencing Fidelity, Implementation Effectiveness and Dissemination



* "EBTs" = Evidence-Based Treatments

Taken from p.286, Allen, Linnan and Emmons (2012)

2.6 Theoretical Models of Implementation

Given that implementation science is a relatively recent field, there exist few formal theories regarding the implementation process with concepts mostly drawn from other disciplines, such as the business and technology sector (Schoenwald et al.,

2012). A theory is important as it allows for a more formalised and systematic approach for evaluating the implementation process over the use of a common-sense based approach (May & Finch, 2009; Nilsen, 2015). Understanding and explaining the factors that influence the implementation process lends itself to three separate theoretical frameworks: classic theories, determinant frameworks and implementation theories (Nilsen, 2015).

2.6.1 Classic Theories

Classic theories derive concepts from other fields such as psychology, sociology and organisational theory. Roger's (2003) Diffusion of Innovations Theory, Brown's (1995) Model of Diffusion and the Theory of Planned Behaviour (Ajzen, 1988) are all notable examples. All in some way emphasise the role of perception and decision-making involved during implementation, encompassing their perceived compatibility, credibility, replicability and context dependency. They are useful for understanding the decision-making processes to adopt a particular innovation by implementers. However, for the purpose of this thesis these theories are less relevant given that the decisions to implement IAPT services were a result of decisions made centrally (Department of Health (DH), 2011a). Nevertheless, the concepts of compatibility and perception of an individual's action relative to others resonate with the critiques about the challenges of implementation (discussed above) and will be worth considering.

2.6.2 Determinant Frameworks

Determinant frameworks conceive of implementation as series of multiple and interacting factors that either directly or indirectly influence the implementation process, such as practitioners' attitude and behaviour (Nilsen, 2015). Damschroder's et al. (2009) Consolidated Framework for Implementation Research is a meta-theoretical framework that conceptualises the domains of implementation research around five areas. These include the intervention's characteristics, the inner setting (service), the outer setting (socio-political, regulatory and financial factors), the individuals involved and the processes by which successful implementation occurs. It is considered a good starting point for examining the factors that may influence

implementation (Schoenwald et al., 2012). Determinant frameworks are useful as they conceive of multiple levels of interacting factors, including the interaction between the context and individuals either implementing or receiving treatment. In many of these frameworks, the relevance of end-users (clients) is not explicitly considered or addressed (Nilsen, 2015), despite their growing inclusion in service planning and appraisal. Therefore, although useful, other theories will need to be considered.

2.6.3 Implementation Theories: The Normalisation Process Theory

Implementation theories comprise of concepts and models that specifically aim to enhance the understanding of the implementation process. A notable example of this is the Normalisation Process Theory (NPT) (May & Finch, 2009). The NPT is a theoretical and explanatory model that attempts to conceptualise the stage at which implementation occurs, including the process of embedding and 'normalising' new and complex innovations into practice (May & Finch, 2009; May et al., 2009; Murray et al., 2010). Having emerged from several inductive qualitative studies, the NPT was initially developed to improve relational working and strengthen the mediating pathways, both within and between services (May et al., 2009). Beginning its existence as a model for integrating new technologies, it has since expanded into other areas, including its use in mental health services (Gask et al., 2010; Gunn et al., 2010; Franx, Oud, de Lange, Wensing & Grol, 2012; Knowles et al., 2013; McEvoy, et al., 2014).

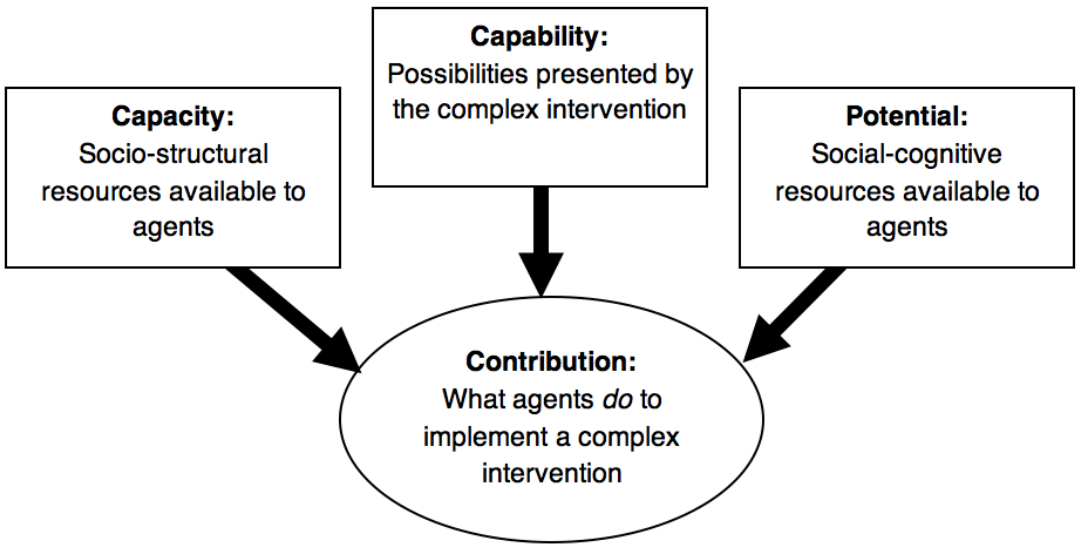
The NPT is a social action theory that comprises of four broad constructs which describe the social and cognitive processes, along with the dynamic and nonlinear relational work undertaken during the implementation process. These constructs include: Coherence (the process and work of sense-making that promote or inhibit successful implementation); Cognitive Participation (the process and work of enrolling individuals to engage with new practice); Collective Action (the work of enacting a new practice); and Reflexive Monitoring (the work involved in the appraisal of new practice, assessing its advantages and disadvantages, usually from client perspectives). All constructs have four subcomponents, with Table 1 outlining these.

Table 1: Normalisation Process Theory: Core Constructs and Subcomponents (May et al., 2010)

Core construct	Type of work	Subcomponents	Description
Coherence	Sense-making work, acted individually and collectively, promoting or inhibiting successful implementation	Differentiation	Understand how a set of practices and their objects is different from each other
		Communal specification	Working together, understanding of the aims, objectives, and expected benefits of a set of practices
		Individual specification	Understanding specific tasks and responsibilities around a set of practices
		Internalisation	Understanding the value, benefits and importance of a set of practices
Cognitive Participation	Relational work enrolling individuals to build and sustain a community of practice around new complex interventions	Initiation	Whether or not key participants are working to drive them forward
		Enrolment	Organising/reorganising oneself and others to collectively contribute to the work involved in new practices
		Legitimation	Ensuring that participants believe it is right for them to be involved, and that they can make a valid contribution to it
		Activation	Participants need to collectively define the actions and procedures to sustain a practice and stay involved
Collective Action	Work of enacting a new practice	Interactional workability	Interactional work that people do with each other, with artefacts, and with other elements of a set of practices, operationalising innovations in a real-world setting
		Relational integration	Knowledge work that people do to build accountability and maintain confidence in a set of practices and each other
		Skill set workability	Allocation work that underpins the division of labour built up around a set of practices as they are operationalised in the real world
		Contextual integration	Resource work - managing a set of practices through the allocation of different kinds of resources and the execution of protocols, policies and procedures
Reflexive Monitoring	Appraisal work of new practice, assessing its advantages and disadvantages, including from client perspectives	Systematisation	Determining how effective and useful an intervention is for them and others, collecting information in a variety of ways
		Communal appraisal	Participants working together, possibly in collaboration or informal groups, to evaluate the worth of a set of practices
		Individual appraisal	Experiential work as individuals appraise effects on them and the contexts in which they are set
		Reconfiguration	Attempts to redefine procedures or modify practices

At its core, the NPT considers implementation as an expression of human agency, incorporating the role of social and cultural norms, attitudes, intentions and shared commitments. It acts as a heuristic device for researchers, emphasising the capacity, capability and potential of implementing agents to better understand their actions and decision-making processes (Figure 2). Ultimately, it is intended to assist researchers and practitioners in understanding the factors that can either facilitate or inhibit implementation (May, 2013). The NPT encourages a broad approach regarding the implementation process, accounting for both provider and client perspectives' equally, the extent to which other theories do not (May, 2013; Murray et al., 2010; Nilsen, 2015).

Figure 2: Resource and Possibilities for Agents' Contributions in the Implementation Process



Taken from May (2013)

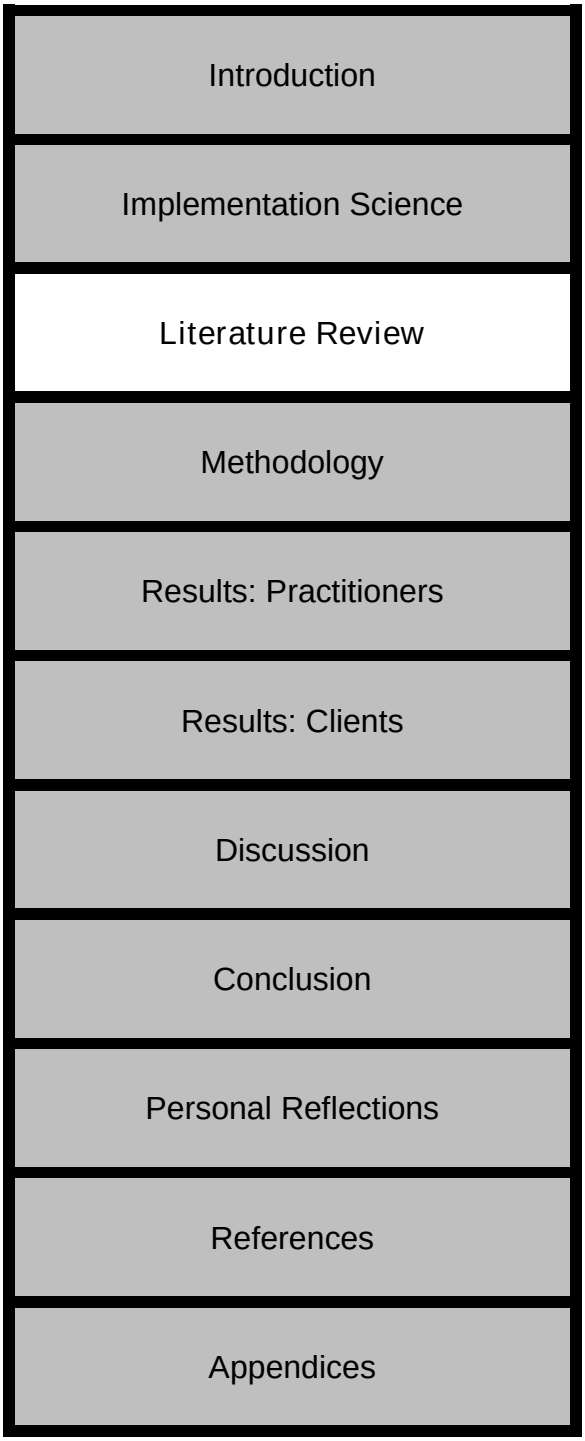
Much of the NPT's early development was related to the implementation of new technologies and e-health applications (May et al., 2009; May & Finch, 2009). Therefore, this creates a potential disadvantage for the focus of this thesis. It's relatively new conception means that robust empirical testing and critiquing of the model is currently limited (Finch, Mair, O'Donnell, Murray & May, 2012; Finch et al., 2013). However, it is increasingly being used in research, particularly in the UK, to analyse qualitatively, the implementation process in a diverse range of settings, the outcomes of which appear to be beneficial (McEvoy et al., 2014). Also, it has been

used to conceptualise barriers in a collaborative care project involving IAPT services and physical healthcare services (Knowles et al., 2013).

The NPT offers a generalisable theory-driven conceptual framework that can be applied across several settings and contexts (May & Finch, 2009; McEvoy et al., 2014), with aspects of the framework adopted and administered flexibly (May & Finch, 2009; May et al., 2010; McEvoy et al., 2014). It also advocates a multi-perspective design, recognising the contribution of different agents in providing a more holistic understanding of implementation (Finch et al., 2012; May, 2013; McEvoy et al., 2014; Wagner, Rau & Lindemann, 2010). On balance, this theory represents a useful tool to structure and operationalise the research process in exploring implementation and will, therefore, be a valuable asset going forward.

2.7 Summary

Implementation science is the study of methods to support and promote the translation of research findings into clinical practice and healthcare policy. It specifically seeks to analyse the implementation process, including exploring the behaviour of health professionals and key stakeholders, to understand which factors are influential in the successful uptake and integration of EBPIs. Significantly, it is increasingly being used within mental healthcare to bridge the research-clinical gap. As a new and developing field, there are already several models and theories emerging that provide a set of conceptual tools to describe and explain the multiple aspects of implementation, the most apposite for the scope of this thesis being the NPT.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

3 Literature Review

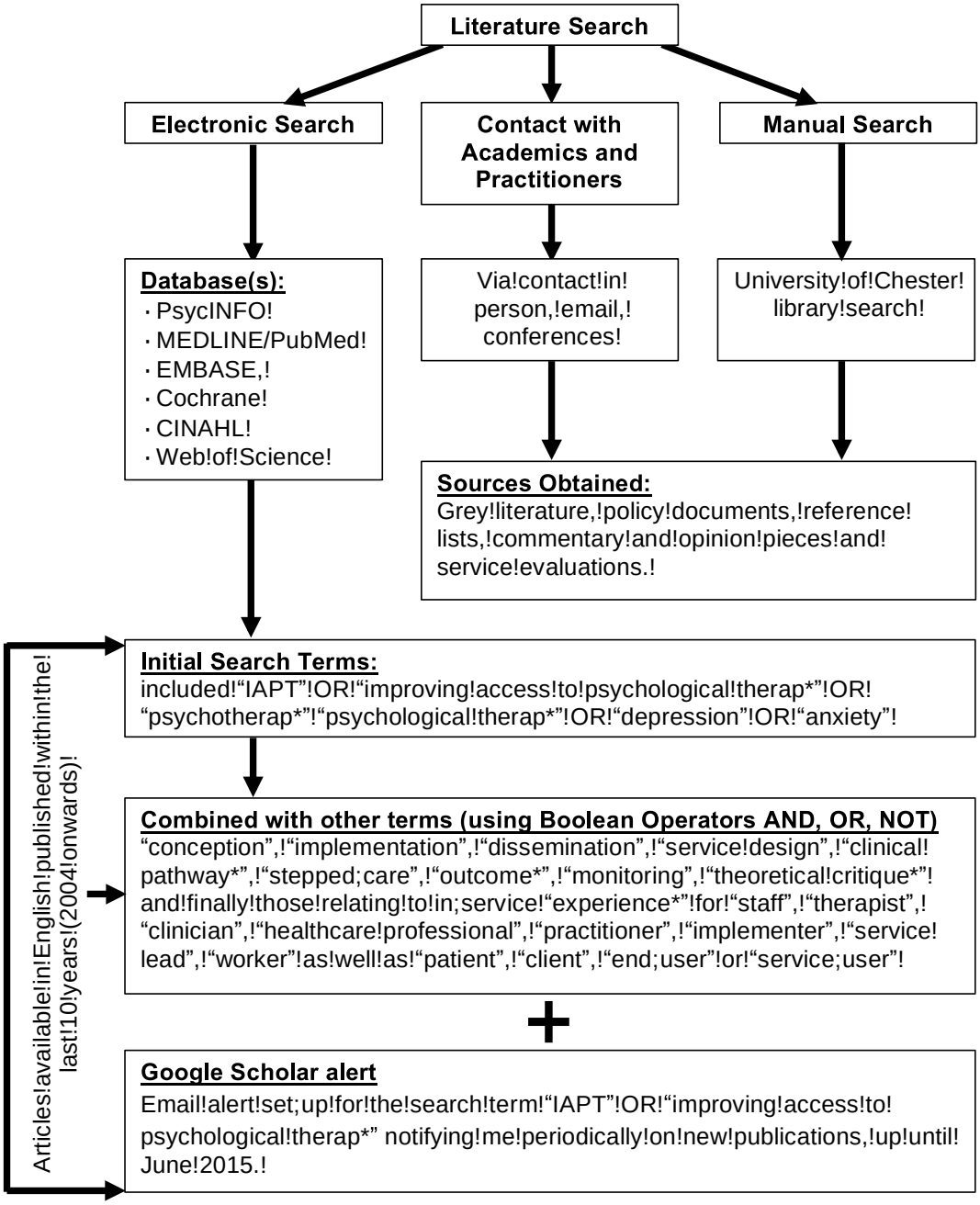
3.1 Overview

In line with the concepts and rationale derived from my brief review of implementation science, this chapter will now present and critique the literature surrounding the Improving Access to Psychological Therapies (IAPT) programme's implementation, along three main areas. These will include and explore: the programme's conceptual basis, including its influence on the delivery model, the current treatment outcomes, and finally any evidence reporting on practitioner and client experience.

3.1.1 Search Strategy

The purpose of the literature review is to serve as "an interpretation and synthesis of published research" (Merriam, 1988, p.6). The use of multiple resources is helpful for uncovering a broad range of literature that, despite a high degree overlap, can still provide some unique articles for reference (Eady, Wilczynski, Haynes & Hedges Team, 2008). Given the complexity of the search area and a limited number of direct empirical studies relating to the IAPT programme, a series of sequential scoping strategies were undertaken, combining searches to boost both sensitivity and specificity (Wilczynski, Haynes & Hedges Team, 2007). Accordingly, the selection of databases was supported using sources chosen by leading systematic review bodies (National Institute for Health and Care Excellence (NICE), 2009a). Figure 3 outlines the search strategy for the literature review. Articles in the electronic database search were screened using the inclusion and exclusion criteria (below), first by scanning the title and abstract, and then by reviewing the whole manuscript, while also removing irrelevant and duplicate articles. Similarly, the reference list of each included paper was individually assessed against the inclusion and exclusion criteria. At the same time, a manual search was undertaken to uncover several other sources, including grey literature, policy documents and service evaluations. Finally, a Google Scholar alert was set-up to keep abreast of newly published articles.

Figure 3: The Search Strategy Process



3.1.1.1 Inclusion and Exclusion Criteria

Given the large number of search results, studies were included or excluded to optimise the review of the literature. In keeping with the original proposal of the IAPT programme, only those studies involving an adult population of working age (16-64 years) were included. Likewise, in accordance with the programme's main focus to treat Common Mental Health Problems (CMHPs), only participants with

these types of conditions were included, excluding those groups with a severe mental illness, personality disorders, primary drug and alcohol problems, or those at significant risk of suicide. Research using an observational, naturalistic design evaluating the IAPT programme and its implementation was given precedence, as was research analysing particular characteristics of the IAPT delivery model; including stepped-care, the application of NICE-approved therapies, practitioner and client experience, self-referral pathways, and session-to-session outcome monitoring. Articles were excluded if they only made a passing reference to the IAPT programme or were judged not to have any direct relevance to the IAPT delivery model. The search also sought to include several commentary and critical articles about the programme to achieve a broader scope of discussion. Only papers that were available in English were included, with a primary focus on UK settings. All articles published since 2004 were included, representing a 10-year period as of 2014.

3.2 Conceptual Basis

To understand the basis for implementing the IAPT programme, it is important to first consider the original aims and objectives behind its conception. Similarly, exploring the conceptual basis will serve to contextualise the emerging evidence, including any ongoing influences on the implementation and operation of services.

3.2.1 The Economics of Happiness

Epidemiological evidence suggests that at any one time, approximately one in six people (15.1% of 13,171 eligible private households) will meet the diagnostic criteria for a CMHP (McManus et al., 2009); a rate that is in line with international proportions (Demyttenaere et al., 2004; Ferrari et al., 2013; Kessler et al., 2005; Wittchen et al., 2011). The social and economic costs associated with this can impact on a person's morbidity, mortality, lifestyle, relationships, and recovery from physical health conditions. The presence of a CMHP can lead to increased healthcare costs, a rise in welfare payments, reduced productivity or attendance in employment, as well as an increased likelihood of being in debt (Mind, 2011). In England, the cost of mental health problems is estimated to demand around £105.2 billion a year alone (Centre for Mental Health, 2010). This figure is almost as much as the yearly budget

for the entire National Health Service (NHS), despite the apparent affordability of psychotherapeutic treatments (Black, 2008; Layard et al., 2007). Consequently, this has led some to argue that CMHPs represent an enormous yet preventable burden of morbidity (Black, 2008; Department of Health (DH), 2011a; Layard et al., 2006; McCrone, Dhanasiri, Patel, Knapp & Lawton-Smith, 2008; Royal College of Psychiatrists (RCP), 2010). Therefore, finding ways to tackle the impact of these conditions represents both a moral and economic imperative.

Although CMHPs have a high incidence and place an enormous burden on both the individual and society, access to Evidence-Based Psychotherapeutic Interventions (EBPIs) are poor and unequal due, in part, to limited investment (Cavanagh, 2014; Layard et al., 2007; McManus et al., 2009; McCrone et al., 2008; Mind, 2010; Seward & Clark, 2010). Significantly, national clinical guidance strongly advocates the use of psychological therapies as a front-line treatment for CMHPs (see Adhering to National Clinical Guidance p.42). Nonetheless, evidence preceding IAPT's inception found that only 24% of those with a CMHP received any psychological intervention and this was mostly in the form of medication (14%) (n=13,171) (McManus et al., 2009). Moreover, evidence suggests that clients tend to prefer talking therapies over medication, with the majority preferring to receive both in combination (Duncan et al., 2010; McHugh, Whitton, Peckham, Welge & Otto, 2013). Importantly, their use is likely more suitable for the treatment of mild-to-moderate conditions for which medication has limited evidence regarding its effectiveness (Cuijpers et al., 2013; Fournier et al., 2010; Kirsch et al., 2008). What's more, the effects of psychotherapy may be longer lasting and potentially cost-effective in the long-term (Cuijpers, van Straten, Smit, Mihalopoulos & Beekman, 2008; Spielmans, Berman & Usitalo, 2011). In light of this, psychotherapeutic interventions appear to represent a preferred, flexible and effective treatment for clients, failing to justify why access to them remains poor and unequal.

It is thought that poor and unequal access to treatment was due to an absence of a clear delivery model, leadership, suitably trained and qualified workforce, and limited support and commitment from central government (McManus et al., 2009; Seward & Clark, 2010). The increasing scale and costs of CMHPs make treating them an increasing priority for policy makers (Harvey, Henderson, Lelliott &

Hotopf, 2009; McCrone et al., 2008; Ferrari et al., 2013). Equally, a lack of provision from the state leads to costs falling on the individual (Patel et al., 2007), which then places greater strain on financial and employment prospects, leading to an endless and exacerbating cycle. For this reason, provision of therapy from the state is conceived as providing far-reaching benefits, for both the individual and society.

3.2.1.1 Proposing a New Therapy Service

Investing in EBPIs as a means to reduce the impact of CMHPs on society, the economy and health services are championed in Layard's Depression Report (Layard et al., 2006). This landmark report gained a wide readership in the UK population (Clark et al., 2009) and was strengthened by a consensus amongst academics, clinicians, economists, and politicians (Seward & Clark, 2010). The proposal centred on the case of unmet need and the potential economic gains of providing such a service that would effectively "pay for itself" (Layard et al., 2007, p.8). Those who 'recover' as a result of an intervention would no longer be seeking incapacity benefit and placing a strain on other healthcare resources. Likewise, those that were supported in work may be less likely to take sick leave and potentially move on to state benefits in the future, although this is not directly observable (Layard & Clark, 2014, p.180). This unique line of reasoning effectively transfers money from the Department of Work and Pensions and invests it into the NHS. Moreover, it was argued that providing interventions earlier would prevent conditions from exacerbating and becoming difficult to treat. For instance, waiting times could reach as high as three to 12-months (Mind, 2014), resulting in unnecessary suffering. Consequently, those with a CMHP would now have access to modern and effective psychotherapeutic interventions, thus alleviating distress in the population.

Equipped with the scientific validation of national clinical guidance and emerging observational data, the implementation of services was advanced. The initial push was geared towards treating adults of working age, the rationale being that CMHPs represented the most pressing health concern for this group. The initiative has since received unprecedented levels of funding (up to £400m) (DH, 2011a), a commitment of which has endured during times of austerity and substantial NHS efficiency savings (NHS England, 2013). Subsequently, these developments are becoming

emulated internationally (Bastiampillai et al., 2014; Bradley & Drapeau, 2014; Dezetter, Briffault, Lakhdar & Kovess-Masfety, 2013; Kobori et al., 2014; Pilgrim & Carey, 2012; Shimuzu, 2011), with a Nature Editorial (2012) even describing the initiative as "world-beating" (p.474), signifying the programme's high impact and merit.

The developments in policy reflect a growing interest and prioritisation from the English government to improve the nation's mental health, echoing the drive to ensure parity of esteem between physical and mental healthcare (RCP, 2013). It also represents the broader ambitions of the government to enable citizens to take more control over their lives by allowing a greater personalisation of services (NHS Constitution, 2014a). Thus, it is clear to see that many factors contributed to the development of this national psychotherapy service; the implication being that without it, it may have never succeeded. Subsequently, what followed was a nationwide rollout for all adults set for April 2015 (DH, 2011a).

3.3 Service Design and Clinical Pathways

3.3.1 The IAPT Delivery Model

The IAPT programme is a specialist psychotherapy service based in primary care, with approximately 90% of people suffering from CHMPs treated within this setting (NICE, 2011a), aligning with client need and preference (NHS England, 2014a; World Health Organization (WHO), 2008a). Fittingly, primary care is an accessible, flexible and effective setting where practitioners can relay information and coordinate care (WHO, 2008a, 2008b). The programme utilises an innovative delivery model that draws together research evidence and clinical expertise in the operation of services. The IAPT Implementation Plan (DH, 2008) provides a general framework and clarity about the form and structure of services, with a reasonable scope for local determination (Clark, 2011). Table 2 summarises the central characteristics of an IAPT service, with select components discussed in further detail throughout this chapter.

Although it is widely accepted that complex interventions require tailoring to different area contexts to avoid implementing a standardised, one-size-fits-all approach (Craig et al., 2008), the directive for how to 'locally determine' the model is left vague. Notably, the subsequent discussion of this literature review reveals that the delivery model is heavily standardised, regulated and monitored. It is probable that this approach is to make treatment allocation more robust and systematic. Also, it likely stems from the growing inclusion of neoliberal practices and audit culture throughout health services more generally (Rizq, 2013). While this method can boost efficiency and fidelity, it runs the risk of a more mechanised approach. To counter this, it is seemingly liberated by an almost tokenistic acknowledgement for local determination. The fact that this local determination is left vague either reflects an oversight or recognition that the basic IAPT delivery model is not suitable in certain contexts, thus needing greater adaptation. These adaptations are what constitute the implementation process and further separates the clinical environment from the research setting. Incidentally, local area context can greatly affect the IAPT delivery model (Byng et al., 2011; Sharp, Dickson & Whittington, 2014), leading to a greater variation in outcomes and organisation of the workforce (Glover et al., 2010; Richards et al., 2012). As will be discovered, the IAPT delivery model attempts to match closely with a research setting by emphasising a greater standardisation in nearly all aspects of its design. Accordingly, the discussion that follows will consider the balance between treatment fidelity and flexibility within service and area constraints.

Table 2: Characteristics of an IAPT service

Characteristic	Description	Rationale
Equity of access	Access to services through multiple routes (a General Practitioner (GP), self-referral or secondary care)	Boost access, particularly using self-referral for harder-to-reach groups
Client-centred assessment	Identifying key issues, setting goals and negotiating a treatment plan	Understanding what is required for treatment considering the social and personal context
Delivering evidence-based treatment	Providing evidence-based interventions as determined by NICE	Ensure recommended treatment for the particular condition is delivered to enable a greater chance of moving to recovery
Teams of therapists	Structuring services according to a stepped-care approach, split between low and high-intensity interventions	Enhance service capacity as people may recover from less intensive treatments
	Regular supervision and close case management	Boost fidelity towards the treatment model and review decisions about stepped-care
	Access to an employment advisor where necessary	Manage concerns about employment or debt, delivering more holistic care
	A hub-and-spoke model	Central base mainly for administrative purposes and treatment delivered in the community
Delivery format	GP surgeries, Jobcentres, service premises, or voluntary organisations. Use of telephone and computerised delivery for support in low-intensity interventions	Improving access and community engagement
Routine outcome monitoring	Using short disorder-specific measures at every therapeutic session	Monitor client progress, judge the level of recovery at an individual, service and national level

3.3.2 Adhering to National Clinical Guidance

High-quality clinical guidelines are a professionally developed and valid expression of evidence-based practice (Kendall, Pilling, Glover & Clare, 2011). Their adoption is a means to maximise and improve outcomes of a service by standardising treatments (via supervision, training and treatment manuals) and clients (via diagnoses and inclusion criteria). Since 2004, NICE, the NHS advisory body for England and Wales, has produced a series of national guidelines which strongly advocates the use of psychotherapies as a front-line treatment for CMHP diagnoses, particularly Cognitive Behavioural Therapy (CBT) (NICE, 2004a, 2004b; NICE, 2005a, 2005b; NICE, 2006; NICE, 2009a, 2009b, 2009c; NICE, 2011a, 2011b; NICE, 2013). Their use provides increased utility and scientific credibility for psychological therapies, representing a decisive factor in their wider dissemination

(Kendrick & Peveler, 2010). They tend to favour research with more controlled methodologies when recommending an intervention, such as the Randomised Controlled Trial (RCT), the implications of which have already been considered in the previous chapter (see Implementation Science - The Research-Clinical Gap p.22). Evidence for CBT remains strong, either in meta-analytical evidence (Hofman et al., 2013) or its application to primary care (Twomey, O'Reilly & Bryne, 2015). Nevertheless, the evidence supporting its use among particular client groups, such as Black and Minority Ethnic (BME) populations, or those living in more deprived areas, remains limited (Hofman et al., 2013). Consequently, these interventions might not apply to areas with different socio-demographic factors and population groups, making their implementation and provision potentially unsuitable.

The sustainability of the IAPT programme will depend mostly on adherence to the recommended clinical guidance (McHugh & Barlow, 2010, 2012; Schoenwald et al., 2011). Compliance with NICE recommended treatments has been associated with improved rates of recovery within IAPT services (Gyani, Shafran, Layard & Clark, 2011). However, guidance is not always followed and can vary regarding their delivery and structure (Glover et al., 2010; RCP, 2013; Richards et al., 2012). Evidence also suggests that certain interventions may be delivered suboptimally and by practitioners who have no formalised or accredited training (RCP, 2013; Shafran et al., 2009). Additionally, clients may receive a less than adequate dosage of therapy as recommended by treatment guidance (Health and Social Care Information Centre (HSCIC), 2014a, 2014b; RCP, 2013). This shortfall indicates that even with a clear delivery model and strategy in place, adherence to recommended treatments is not always possible. The reasons why are not clear and could benefit further investigation, particularly if it impacts on service effectiveness as evidence seems to suggest (Gyani et al., 2011). Perhaps the applicability of the delivery model in clinical settings represents an issue, although the extent of this in IAPT services is unknown.

3.3.3 The Stepped-Care Approach

Enhancing the availability of interventions by optimising their delivery is important for meeting the demand for psychological therapies. NICE recommends that a

stepped-care approach is used to organise the provision of services. This model has two main components: the first being that the treatment provided is the least intensive possible that is appropriate to a client's condition (Principle of 'Least Burden'); the second being that the course of therapy can be modified to match a client's needs based on treatment outcomes and clinical judgment ('Self-Correcting' Mechanism) (Bower & Gilbody, 2005). In other words, those who are not improving can be stepped-up to more intense interventions.

Using this model, IAPT services can adapt and stratify their approach accordingly, with more intense treatments reserved for people who suffer from severe and debilitating psychological distress. As the majority of people accessing services could stand to benefit from a less intense intervention, the model attempts to maximise capacity and capability from finite resources. Stepped-care makes clear a divide in the levels of treatment according to a client's condition, separated along three steps in primary care, with higher steps incorporating more sessions and increased brevity (see Table 3).

The organisation of stepped-care is important from a cost-efficiency perspective. Hammond et al. (2012) report a 36.2% cost-efficiency saving regarding the use of low-intensity, over-the-phone therapy compared with face-to-face interventions. Similar evidence suggests the use of brief, CBT-based interventions can lead to a clinically significant reduction in symptoms (Bennett-Levy et al., 2010; Bower et al., 2013; McHugh, Gordon & Bryne, 2014; Papworth, Marrinan, Martin, Keegan & Chaddock, 2013; Stiles et al., 2006, 2008), and are useful for accommodating to a client's lifestyle (Kenwright, 2008; Mansell, 2007). Notably, Bennett-Levy, Richards and Farrand (2010, p.3) consider the uptake of low-intensity interventions to be "a revolution in mental healthcare". The emphasis on low-intensity therapies is crucial in delivering a high-volume, fast access throughput of clients that has come to characterise IAPT services. There has been growing interest in low-intensity interventions, not only because they require less therapist input and time, but also because they encourage self-help and self-management (Bennett-Levy et al., 2010; IAPT, 2011a), potentially reducing a risk of relapse.

Table 3: Summary of NICE′s Recommendations for the Psychological Treatment of Depression and Anxiety Disorders (NICE, 2011a)

Focus of the intervention	Nature of the intervention
Step-1: All known and suspected presentations of symptoms	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions
Step-2: Mild-to-moderate conditions; persistent subthreshold symptoms	Low-intensity psychological interventions, medication and referral for further assessment and interventions
Step-3: Moderate-to-severe conditions; persistent subthreshold symptoms or a mild-to-moderate condition with inadequate response to initial interventions	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step-4: Severe and complex symptoms; severe self-neglect; risk to life	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care

Alternatively, stratified care involves assigning a client directly to a particular level of treatment intensity based on the nature and severity of their psychological distress, as opposed to emphasising low-intensity treatment. The optimal content and organisation of stepped-care versus stratified care is unclear, as is the decision-making processes involved (Bower & Gilbody, 2005; Delgadillo, Gellatly & Stephenson-Bellwood, 2013; Richards et al., 2012). Central to the design of services is the balance between stepped versus stratified models of care (Richards et al., 2012). The latter is harder to implement as it requires an accurate knowledge of the client accessing a service, something that will be difficult in light of fast access, high-volume throughput. Accordingly, Chan and Adams (2014), when evaluating the stepped-care model in an IAPT service, found no differences in baseline treatment scores for both low and high-intensity interventions, suggesting a lack of discrimination between steps and inappropriate care. It may be a consequence of the emphasis on low-intensity provision which could force services to assign people to treatment inappropriately, perhaps due to a lack of suitable time in assessment as other evidence corroborates (Cairns, 2014; Di Bona, Saxon, Barkham, Dent-Brown & Parry, 2014). Consequently, these pressures could impact on the utility of the

stepped-care model by solely enhancing low-intensity interventions, regardless of the severity of the condition.

A higher step-up rate has been associated with an increased recovery rate in IAPT services (Gyani et al., 2011) however, its organisation has been found to vary significantly between sites (Glover et al., 2010; Richards et al., 2012). Across four IAPT sites, Richards et al. (2012) found that the proportion of clients directly allocated to high-intensity treatment ranged from 3% to 45%, with stepping-up rates rarely exceeding 10% (n=7,698). This rate is similar to the analysis performed by Radhakrishnan et al. (2013), involving five IAPT sites in the East of England, at 13.3% (n=8,464). Additionally, the proportion of high-intensity therapists can be highly inconsistent in IAPT services (25% to 93%) (Glover et al., 2010), further suggesting a wide variation in the organisation of stepped-care. Richards et al. (2012) argue that this is unsurprising, as NICE guidelines are not explicit and offer no formal design about its structure.

Due to the observational nature of this evidence, the processes of implementation and the reasons for its organisation cannot be determined. Then again, similar patterns have been found in meta-analytical evidence reporting there being a wide range in terms of treatments, professionals and steps involved (van Straten, Hill, Richards & Cuijpers, 2015). More concerning is that the superiority of the stepped-care model over usual care regarding clinical effectiveness is yet to be scientifically verified (Firth, Barkham & Kellett, 2015; Mukuria et al., 2013), particularly within UK settings. It is intriguing that in such a small number of services, the range can be so vast. What's more, the low stepping-up rate suggests that the use of the self-correcting mechanism (Bower & Gilbody, 2005) is under-utilised in IAPT services. Consequently, the emphasis on low-intensity treatments may not have the suitable support method in place to allow the stepping up of clients. Notably, other evidence has reported a high level of disengagement (51%) among those receiving low-intensity treatments (n=92) (McHugh et al., 2014). On balance, the lack of evidence currently supporting stepped-care's superiority over other models suggests that its implementation might be the result of seeking functional and operational gains. Hence, it might not be completely empirically-driven, the implications of which will have ramifications for clients being allocated to inappropriate treatment.

3.3.4 Accessing an IAPT Service: Referral and Assessment

The access rate target for all those suffering from a CMHP within a given population is set at 15% (DH, 2011a). This goal has led to a range of unique and innovative practices that are attempting to lessen the barriers to access. Increasing the availability of services and interventions is one of the primary drivers of the IAPT programme. Overall, waiting times have improved since its inception, although a majority of services still fail to hit the 28-day access rate target (Price, 2013) and waiting times vary widely (Mental Health Today, 2015).

The trial and success of self-referral pathways in the Newham IAPT demonstration site led to their use being adopted throughout the programme during its rollout (Clark et al., 2009; Clark, 2011). This innovation was trialled to boost access among underserved populations, such as BME groups. Those self-referring have been found to be more closely representative of the service catchment area, suitable for treatment, and require fewer sessions for achieving a move to recovery (Brown et al., 2014; Clark et al., 2009; Gyani et al., 2011). Evidence suggests that the use of self-referral can increase access rates, though its implementation is not available across all services (Brown, Boardman, Whittinger & Ashworth, 2010; Brown et al., 2014). Brown et al. (2010) point out that self-referral is something that has been available within the private and voluntary sector for some time as it allows for easier access. Thus, this can be crucial in helping to attract harder-to-reach groups who are reluctant to seek treatment due to the role of stigma. Consequently, these advantages appear to support its use in NHS mental health services, particularly if it enhances equitable access.

Having said this, there are some concerns that services may feel overwhelmed by adopting a self-referral pathway, or that it might favour a particular type of client (Brown et al., 2010; IAPT, 2008a; Mathers & Mitchell, 2010); however, evidence exists to refute this (Brown et al., 2014; Clark et al., 2009; Gaynor & Brown, 2013). Secondly, a self-referral pathway risks sidestepping the role of other highly trained professionals, such as the GP, who are important for gatekeeping and coordinating care. Conversely, this may be useful for engaging those who do not wish to consult

with their GP about their issues (Gaynor & Brown, 2013; Lovell et al., 2014). In any case, optimising referral pathways requires the collaboration and expertise of GPs and other professionals (Byng & Gask, 2009; Gyani et al., 2012; Knowles et al., 2013). Local examples have praised the support of local GPs as being pivotal in the development stages of establishing an IAPT service (Gyani et al., 2012; Stern, Hard & Rock, 2015). In parallel with this, an increased awareness of NICE recommended treatments in GPs has been associated with increased contact with IAPT services (Gyani et al., 2012), further supporting the need and value of their engagement. As yet it is not clear which pathway is most appropriate with not all services implementing a complete self-referral pathway, suggesting variable access routes between sites.

The stage of assessment is crucial to the function and operation of IAPT services. Presently, this process can vary (Vail, Adams, Gilbert, Nettleingham & Buckingham, 2012), with some services conducting assessment over-the-phone, and involving less experienced practitioners (Cairns, 2014; Di Bona et al., 2014; Jones et al., 2013; Mathers & Mitchell, 2010), raising concerns about their competency in assessing complex cases (Cairns, 2014; Rizq, 2012b). Also, there is evidence to suggest negotiating a course of treatment with a referring client can be a taxing and uncertain process (see Entering and Engaging with Services p.74). Consequently, this has led to the development of formalised techniques which attempt to systematically frame the assessment process and focus decision-making (Vail et al., 2012). The issue becomes more complicated when considering the poor diagnostic practices of referring health professionals (Clark et al., 2009; Glover et al., 2010; Kendrick et al., 2009), together with the poor recording practices in IAPT services (Glover et al., 2010). There are bound to be operational constraints influencing a service's ability in conducting the assessment session. This will likely be influenced by implementing a greater emphasis on low-intensity treatments rather than stratified models of care, as discussed previously (see The Stepped-Care Approach p.44). Evidence exists to suggest it is worthwhile to invest in a robust assessment session for identifying factors that could adversely affect the course of treatment, such as social, biological and cultural factors (Grant et al., 2014; Green et al., 2015), or the impact of other comorbid conditions, like a personality disorder (Goddard, Wingrove & Moran,

2015). However, as already described this could be an increasingly difficult task in light of pressures that emphasise fast access throughput.

In considering this, it is necessary to note that evidence has reported over half of those entering a service fail to enter treatment (HSCIC, 2014a, 2014b; Richards & Borglin, 2011), despite a sizeable majority being considered suitable for an intervention (Clark et al., 2009; Glover et al., 2010). Non-attendance in treatment has been associated with specific site factors as well as a client's complexity, severity and duration of their condition (Cairns, 2014; Di Bona et al., 2014). Specific site factors refer to an observed increase of disengagement in the Doncaster demonstration site, which emphasised a low-intensity, high-volume based approach, compared with the Newham demonstration site (Di Bona et al., 2014). Again, this indicates that operational demands and outside pressures prioritising increased and faster access could play an influential role in deciding to implement certain practices. The fact that many clients fail to make it into treatment indicates that a large proportion are not comfortable with the access procedure. Perhaps this is because of a perceived urgency in the process, or that treatment is felt to be inadequate, possibly due to a greater emphasis on quicker access and hence less stratification. Nevertheless, depending on a client's condition and severity, treatment guidance does advise on which step they should be entering at, but again these are not always followed as evidence presented earlier highlights.

Cairns (2014) randomly selected 50 clients who were re-referring on more than one occasion into an IAPT service between 2009-10. Cairns findings suggest, somewhat tentatively, that repeat non-engagement is more likely in cases with increased clinical complexity. Also, the results report that these clients were less likely to engage with briefer interventions. Cairns contends that the use of a brief telephone assessment session is likely inappropriate, particularly for those with more complex conditions. Di Bona et al. (2014) echoes and somewhat replicates these conclusions by analysing the common factors linked with treatment non-attendance. In light of budgetary constraints and growing pressures on services, it may be necessary to use over-the-phone techniques for assessment and less experienced staff. However, though having a limited sample size, the findings from both Cairns (2014) and Di Bona et al. (2014) suggest this is not advisable. It is clear that there is a need for further evidence about

what is the most effective approach to referral, access and assessment, including understanding the decision-making processes behind these practices.

3.3.5 Implementing a Follow-Up Procedure

Following-up on treatment is considered to be important (Gyani et al., 2011). Contemporary mental health services have begun to implement a follow-up procedure post-treatment, however it is not always available and evidence regarding its use is limited (Clark et al., 2009; Glover et al., 2010; Gyani et al., 2011). The evidence that does exist indicates a degree of drop back in treatment scores, indicative of a diagnosable CMHP (Clark et al., 2009). There is evidence to suggest that relapse rates for those engaging in psychotherapy beyond two years are high, but admittedly lower than those not receiving treatment, although the basis for this is narrow and potentially includes biased research (Steinert, Hofmann, Kruse & Leichsenring, 2014). What's more, the evidence for sustainable recovery from low-intensity treatment is also limited (Rodgers et al., 2012), as is the use of a follow-up procedure in primary care research (Linde et al., 2015). The basis for a follow-up procedure could serve a great benefit, however, as it currently stands, it is not clear why some services choose to follow-up and some do not, but decisions are likely made in the interests of operational and budgetary constraints (Gyani et al., 2011). Consequently, without sufficient evidence, it is not yet possible to confirm whether IAPT services produce sustainable outcomes for the majority of their clients.

3.3.6 Completing the National Rollout of IAPT Services

The initial rollout of the IAPT programme commissioned two demonstration sites, chosen on the basis of them each serving a vastly different catchment area and casemix; something that was recognised from the outset (Clark et al., 2009). In turn, this resulted in a different type of model implemented between sites, one emphasising a high-volume throughput, low-intensity style provision, and the other emphasising the opposite. However, both sites eventually developed to prioritise low-intensity interventions to meet the increases in demand (Clark et al., 2009; Kuhn, 2011; Richards & Suckling, 2009). The numbers entering the service (n=3,471), waiting times (3-4 weeks), recovery rates (55-56%), employment

outcomes (5%), and data completion (88.3-99.6%), were all considered to be better than expected, (Clark et al., 2009). These outcomes were deemed to be the result of providing a greater proportion of low-intensity treatments, supporting their use in improving service throughput and efficiency. Nevertheless, the analyses of these sites are observational; therefore, the direct impact of service organisation cannot be inferred, although it does illustrate how certain aspects of the delivery model need to adjust to suit and respond to local area context and macro-level pressures.

Following the demonstration sites, 11 pathfinder sites were established to develop specialist services for certain groups, dependent on their catchment area. Services reported acceptable recovery rates (average 49%) and high satisfaction rates, although certain aspects of provision varied considerably (IAPT, 2008a). The dissemination and implementation of the programme's national rollout were divided into three waves, across three years. Therefore, this allowed the initiative to build gradually, while testing and refining their approach. By March 2012, the IAPT programme was partway through its national rollout and had reportedly treated more than 1 million people, with progress deemed to be in line with and, in some cases, exceeding expectations (IAPT, 2012). Recovery rates had steadily improved from 16.9% to 45.6% for those completing treatment, and 45,610 people were reported to be no longer receiving sick pay or incapacity benefits, supporting the initiative as being a success. However, the average recovery rate has not much improved on these figures, with the expansion of the programme also leading to a greater variation in outcomes (HSCIC, 2014a, 2014b). Indeed, with the expansion of services, there are concerns among the workforce about reaching increasingly difficult targets, such as those for rates of access and recovery (IAPT, 2012). It is important from a policy and research perspective to understand how to reduce the impact of this variability and boost treatment outcomes throughout all IAPT services.

Glover et al. (2010) analysed data from 32 'first-wave' IAPT sites during their first full year of operation. Recovery rates for those considered to have completed their treatment were 56.4% (n=10,439), although this rate was 36.8% when considering the intention-to-treat sample (n=22,356), assuming initial scores remained unchanged. Of interest here, the variation in the delivery model among sites was found to be significant. Delgadillo et al. (2014a) point out that the methods used to

calculate effect sizes, define outcomes and aggregate data all differed between these sites, so interpreting these findings requires caution. Nevertheless, this evidence again highlights the varied and dynamic nature of implementation in IAPT services.

Gyani et al. (2011) provide a subsequent analysis on the first-wave site data as a function of compliance with NICE guidance. A higher stepping-up rate ($p<0.001$), an increased median number of sessions, for both intensities ($p<0.001$), increased service size ($p<0.001$), increased proportion of high-intensity therapies ($p=0.018$), and more experienced therapists ($p=0.003$), were all associated with improved recovery rates (where an International Classification of Diseases (ICD-10) diagnosis was reported, n=11,535). In contrast, a higher baseline treatment score severity was associated with lower recovery rates ($p<0.001$). This research was not a controlled experiment due to its feasibility; therefore, its conclusions are restricted. Nonetheless, given such compelling evidence, it is not clear why services fail to provide an adequate level of therapy, as recommended by treatment guidance. Gyani et al. (2011) note that services may have changed their policies over time, hence applying a static measure to an evolving service context will have its shortcomings. Consequently, this type of investigation would benefit from more rich, in-depth and exploratory techniques regarding operational processes.

3.4 Theoretical Critiques on the Conceptual Basis and IAPT Delivery Model

Given the sheer number of sufferers and the substantial financial burden placed on the individual and society, ensuring equitable and timely access to effective treatments is both an innovative and welcome advance. Although this may be true, it would appear that the evidence supporting the IAPT initiative, at its inception, was limited. Notably, research evaluating the demonstration and first-wave sites were restricted to non-randomised, observational designs, each reporting substantial limitations in regard to record keeping, high client dropout, high variability, and missing data for diagnosis and employment indicators (Böhnke, Lutz & Delgadillo, 2014; Clark et al., 2009; Delgadillo et al., 2014a; Glover et al., 2010). Comparing one of the IAPT demonstration sites with a demographically similar non-IAPT site, Mukuria et al. (2013) found only small improvements in support of the former, with

any observed differences being non-significant at four and eight-month follow-ups. Comparatively, before the IAPT programme's announcement in 2007, Bower and Gilbody (2005) had conducted a narrative literature review of stepped-care provision and concluded that the evidence relating to its superiority over other models was limited. More recent evidence has also failed to demonstrate its superiority over other models (Mukuria et al., 2013; Firth et al., 2015; van Straten et al., 2015), producing mainly equivalent outcomes. Despite this, the IAPT initiative went on to champion a stepped-care approach, perhaps to treat larger quantities of people (Clark et al., 2009). Given a lack of research about how best to organise and optimise stepped-care in IAPT services, delivery models between sites vary widely (Glover et al., 2010; Richards et al., 2012), likely being a consequence of limited empirical research.

Presently, there is limited evidence on the cost-effectiveness of an IAPT service in practice. Based on national data, the cost-per-client completing treatment (£656.79) (IAPT, 2012) appears to be in line with and exceeding the original estimates calculated by Layard et al. (2007) (£750). However, this could be due to a greater proportion of low-intensity interventions being delivered (HSCIC, 2014a, 2014b), which would misrepresent cost-benefit analyses. Some have found costs to be higher than this (Radhakrishnan et al., 2013) while other evidence found estimated costs to be far exceeding the values proposed in the DH impact assessment guidance for commissioning (Griffiths & Steen, 2013b). Mukuria et al. (2013) reported that there was considerable uncertainty regarding the cost-effectiveness of an IAPT demonstration site when compared with another similar non-IAPT site. Although outcomes could have been impacted by the initial setting up of the demonstration site, it did report elsewhere that recovery rates were better than expected (Clark et al., 2009). Additionally, research relating to the programme's impact remains mixed, with some reporting savings in other healthcare sectors (de Lusignan, Chan, Parry, Dent-Brown & Kendrick, 2011), while others highlight an increase in antidepressant prescribing, despite the programme's inception (Sreeharan, Madden, Lee, Millett & Majeed, 2013). The limited and somewhat contradictory evidence has led some to criticise the programme's implementation as being too hurried, without an adequate reflection and consolidation of proof, reflecting a political imperative, rather than a scientific one (Barrett, 2009; Cooper, 2009; Scanlon & Adlam, 2010, 2013; Walker,

2012). In short, the centrally-driven, top-down process of implementing the IAPT programme was orchestrated to improve the rate of its dissemination. Nevertheless, the decision to advance with the initiative in light of these concerns runs counter to the central empirical drive of the IAPT programme, hence making achieving these goals problematic.

Some criticise the inclusion of NICE guidance as further emphasising a positivistic, biomedical and westernised understanding of CMHPs (Mollon, 2009; Loewenthal, 2015; Guy et al., 2012; Marziller & Hall, 2009; Pietroni et al., 2012; Williams, 2015). The underlying biomedical assumption of the programme presents many issues, namely the contested nature of diagnostic labelling, together with the emergence of stigmatising attitudes and a potential for self-blame in clients (Moloney, 2013). Likewise, this approach runs the risk of simplifying a client's condition, turning their issues inward, despite environmental factors likely playing a critical role. This trend could lead to a perversion in care as treating symptoms is privileged over more holistic approaches, ultimately leading to an abstraction and depersonalisation of a client's condition (Rizq, 2012a). This simplistic and reductionist approach, therefore, has implications for claims regarding the programme's utility, with its opponents suggesting that its aims are ideological and unfounded (Rizq, 2011; Marziller & Hall, 2009; Pietroni et al., 2012). Naïve assumptions could lead to an idealisation in targets and outcomes, putting a strain on practitioners and the implementation process (Rizq, 2011; Steel, Macdonald, Schröder & Mellor-Clark, 2015). Rizq (2011) argues that the political, economic and ideological drive underpinning the IAPT programme will likely result in increased pressure on services to achieve targets, which emphasise quantity over relatedness and dependency. Equally, practitioners working within the programme have expressed similar concerns (Binnie, 2015; Bogart, 2015), highlighting that it is not only those outside the initiative who can be critical of its process.

Cooper (2009) points out that each group of individuals supporting the IAPT programme, such as academics, clinicians and politicians, are not necessarily working towards the same common goal. The business case underpinning the IAPT programme's development certainly played a central role in acquiring investment (Cooper, 2009; Kendrick & Peveler, 2010), justifying it on the grounds of returning

people to work. However, NICE (2009c) guidance does not recommend any treatments regarding helping individuals return-to-work, specifically citing a lack of evidence for this (Hashtroudi & Paterson, 2009). What's more, a return-to-work agenda might influence the therapeutic process as the therapist could be seen to have a preconceived idea of what the client's needs and goals are (Wesson & Gould, 2010). Walker (2012) points out that government policy and academic consensus tend to regard work as a panacea for recovery from CMHPs, which stems from a neoliberal political context. This pattern has led some to criticise the IAPT programme as being a treatment for worklessness, as though an individual's condition was their fault and not a victim of circumstance (Scanlon & Adlam, 2010, 2013; Moloney, 2013; Parker, 2014; Walker, 2012). Rather, a return-to-work agenda, sanctioned by central government is seen to medicalise poverty, debt and worklessness as though it was something to be 'cured' (Scanlon & Adlam, 2010, 2013; Parker, 2014). Thus, unemployment and worklessness are conceived as being related to an individual's cognitive function and failure to act (Scanlon & Adlam, 2010). Equally, the use of close regulation and bureaucratic systems might collude to remove the possibility of doubt, and encourage an individualistic ideology that further regards the client at fault for their condition, as opposed to being the result of a poor political system and unequal society (Parker, 2014). Accordingly, this resonates with sociological theorists such as Foucault, Sedgwick and Scheff who argue that implicit in the classification system of mental health, is the alleged scientific justification for treating people who are not in keeping with the status quo, usually determined by, and suiting the needs of those in power (Perring, 2010). Those opposing the Layard et al. (2006) preoccupation with the economics of happiness criticise it for being too naïve and individualistic, as it ignores other important societal factors, such as work barriers and social inequality (Midlands Psychology Group, 2007; Marziller & Hall, 2009; Mollon, 2009; Pietroni et al., 2012). Having said this, Layard et al. (2006) recognised the importance of addressing inequalities in society. On balance, it seems that the basis for getting people back to work using psychological therapies might be ideological and possibly even damaging. Significantly, this will likely have an impact on continued targeting and the implementation process.

Those unemployed tend to report a strong desire to regain employment (McQuicken et al., 2003), and it is often considered good for an individual's mental wellbeing as it helps develop a sense of purpose, structure and identity (Black, 2008; Grove, 2006; Waddell & Burton, 2006). Furthermore, a return-to-work agenda has been successfully introduced into therapeutic practice, although this must be done sensitively (Wesson & Gould, 2010). Historically, the coordination between the NHS and employment programmes has remained limited despite their apparent influence on one another (Black, 2008). Psychotherapeutic interventions are increasingly being assessed based on their financial function (Arends, Baer, Miranda, Prinz & Singh, 2014), with the NHS continuously being called upon to return people to work (Harvey et al., 2009). There is research underway to analyse whether the IAPT programme can help clients re-enter the workforce, with emerging pilot data looking promising (Cameron et al., 2012; Hogarth et al., 2013). All things considered, the underlying conceptual basis for helping people regain employment, or move off welfare payments, could be a valuable addition to the psychotherapeutic encounter. Be that as it may, if targets governing the IAPT programme are ideological due to the economics of happiness and a narrow understanding of mental health, then these goals would likely be unworkable.

3.5 Routine Outcome Monitoring within IAPT Services

A central component of the implementation of IAPT services is the use of Routine Outcome Monitoring (ROM) for screening and assessing client progress (Clark et al., 2009; DH, 2011a). Its intended purpose is to help inform practitioners, clients and national developments of the programme. In short, their routine use provides live feedback to help monitor client progress, including their move to recovery or deterioration (see Figure 4) (Boswell, Kraus, Miller & Lambert, 2015; Clark et al., 2009; Lambert, 2010; Shimokawa, Lambert & Smart, 2010). It also reflects a growing emphasis on clinical governance in health and public services more generally. Accordingly, their use is worth considering for evaluating the implementation process.

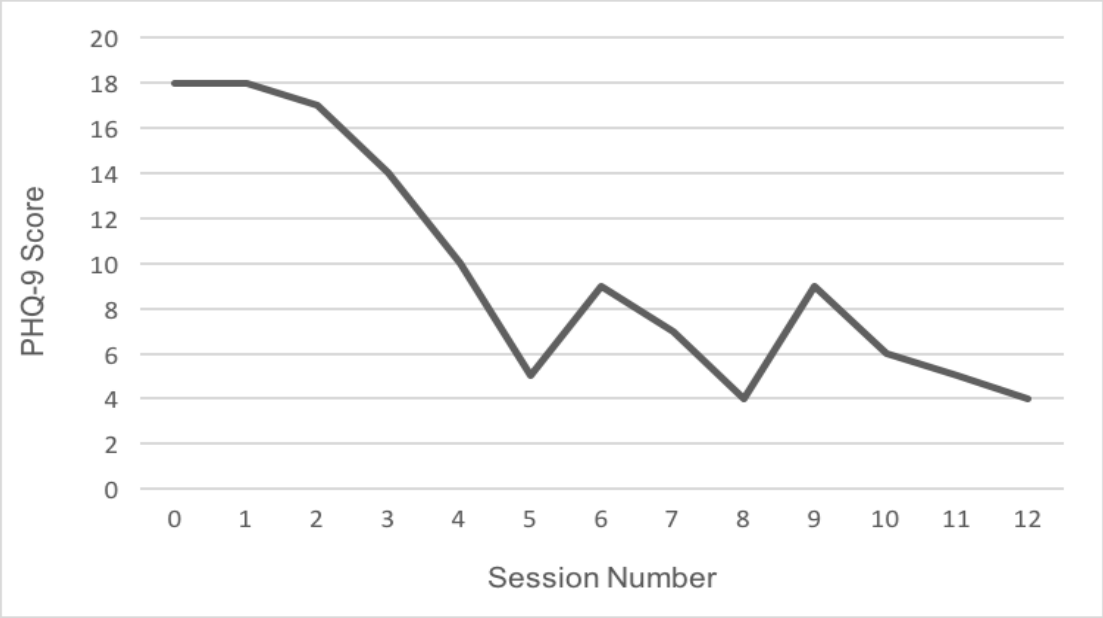
All measures within IAPT services are typically diagnosis based, disorder-specific, self-reporting, relatively short and simple, empirically validated, and free-to-use

(DH, 2011a). Completing each measure tends to require the counting of symptoms which corresponds to a score that is indicative of a CMHP and its severity. An IAPT service can determine whether a client has moved to recovery during their engagement, by using the first and final treatment scores. Defining recovery is taken to mean dropping below a specified cut-off score that represents the clinical threshold for a CMHP, depending on the measure. To achieve recovery a client needs at least two treatment scores, and their first and final score need to cross the clinical cut-off. At present, targets require that at least 50% of those treated end up "moving to recovery" (Clark & Oates, 2014, p.3).

Upon entering a service, additional data is also recorded, such as demographic and diagnostic information. In keeping with the conceptual basis for the programme's inception, employment outcomes are also recorded where appropriate. Finally, clinical leads and service managers report on various regulatory and quality assurance measures for conveying service activity in detail (IAPT, 2008b).

There is particular emphasis on data collection with a 90% data completion rate required of all services (IAPT, 2011b). By mandating input at each and every contact with a client, a service is able to reach this completion rate. Subsequently, this can be beneficial for calculating more accurate rates of recovery. With the use of ROM, services are less likely to overestimate treatment effectiveness, compared with less frequent outcome monitoring practices (Clark et al., 2009). Likewise, their brevity allows for easier administrative input that can be conducted using several formats, enhancing the flexibility of treatment and data input (Cavanagh, Seccombe & Lidbetter, 2011; Hammond et al., 2012; Price, 2010). Given that the programme draws upon several formats for therapeutic provision, this approach is useful.

Figure 4: Example of Client Progression Chart for the Patient Health Questionnaire-9 (PHQ-9)[1]



[1](Kroenke, Spitzer & Williams, 2001). Used for identifying symptoms of depression.

3.5.1 The Rationale for ROM

Historically, the collection of data in mental health services has been characteristically poor (Jacques, 2008; Stiles et al., 2006, 2008) and continues to make service redevelopment difficult (Appleby, Baird, Thompson & Jabbal, 2015). Stiles et al. (2006) found that for services treating mental health problems, data completion rarely exceeds 33-38%, even with the use of a standardised measure. ROM affords services the ability to develop a more accurate data profile. Its use is central to the development of practice-based evidence and is a valuable resource for informing current and future implementation research (Barkham, Hardy & Mellor-Clark, 2010; McHugh & Barlow, 2010). Their use can help enhance treatment fidelity, closely aligning therapeutic procedures with the research trials from which they originated (McHugh, Murray & Barlow, 2009; Schoenwald et al., 2011). Importantly, ROM continues to serve a purpose of being a validation tool that encourages ongoing investment from central government, as the programme can demonstrate its effectiveness more robustly (Seward & Clark, 2010). Indeed, other areas of mental healthcare remain illusory because of their lack of ROM practices

(Addicott, Maguire, Honeyman & Jabbal, 2015). Consequently, this makes comparisons between IAPT services and other providers difficult to ascertain. Therefore, the success of the programme may be due, in part, to the simple fact that it can amass a greater body of evidence to what has gone before it.

Systematic review evidence identifies a treatment benefit for the use of ROM in practice (Boswell et al., 2015; Knaup, Koesters, Schoefer, Becker & Puschner, 2009). It can help identify those who are not receiving any benefit or may even be experiencing harm from treatment (Boswell et al., 2015; Delgadillo et al., 2014b; Lambert, 2010; Shimokawa et al., 2010). Treatment can then be reformulated, delivering therapy to those who stand to benefit most, thus prioritising a therapist's time. There are various considerations regarding cost and efficiency savings for improving this process within stepped-care approaches (Delgadillo et al., 2013; Hammond et al., 2012; Radhakrishnan et al., 2013). They can be used to help inform practitioners both within and beyond the therapeutic session, identifying and correcting for therapist biases and blind-sidedness (MacDonald & Mellor-Clark, 2014; Lambert, 2010; Shimokawa et al., 2010). Delgadillo et al. (2014b) use initial treatment scores (within the first three sessions) to accurately predict which clients are likely to move to recovery more than 70% of the time (n=1,850). However, the ability to accurately predict poor treatment outcome was found to be low in advance of the penultimate session. From a client's perspective, there is evidence to suggest that the demand and support for this type of approach is favourable (Badham & Young Minds, 2011; Boswell et al., 2013; Unsworth, Cowle & Green, 2012; Youn, Kraus & Castonguay, 2012). Moreover, their use can help enhance the knowledge and recognition of other health professionals for identifying mental health problems, including that of the GP (Kendrick et al., 2009).

Standardising ROM allows the programme to perform cross-site comparisons between services. By receiving scores from all services using a systematic audit system, the initiative can build a composite picture around service access, engagement and overall outcome, which can then be used to benchmark and rank services (Clark et al., 2009; Delgadillo et al., 2014a; Glover et al., 2010; RCP, 2013). However, analyses are currently limited by a high degree of heterogeneous data and an unknown effect of casemix on outcomes (Delgadillo et al., 2014a). Engagement

with a service can be influenced by a combination of social, economic, accessibility and institutional factors (Barkham et al., 2012; Black, 2008; Marmot et al., 2010). Accordingly, these will need special consideration when ranking and comparing services using standardised monitoring techniques. These effects remain somewhat unknown, and will remain this way until further data is collected and interpreted (Delgadillo et al., 2014a). On balance, it appears that the use of ROM could benefit the service greatly regarding improving recovery rates, cost savings and feeding back during implementation. Nevertheless, there is still some way to go as the use of brief, symptom-orientated measures will only provide a partial account into the reality of things.

3.5.2 Current Limitations in ROM and their Place within the IAPT Framework

ROM is intended to enhance clinical judgment, not replace it, with the therapist still playing a central role in determining client progress. One of the main barriers to successfully implementing ROM concerns practitioner resistance. This resistance can be influenced by a combination of personal beliefs, attitudes and prior experiences (Boswell et al., 2015; Mellor-Clark, Cross, Macdonald & Skjulsvik, 2014). Resistance may stem from anxiety about being under constant scrutiny or feeling disempowered (Rizq, 2012b; Steel et al., 2015; Walklet & Percy, 2014). The measures might be deemed too narrow, restrictive, and not clinically meaningful or helpful, instead considering them to be intrusive, burdensome and disruptive (Boswell et al., 2015; Unsworth et al., 2012). Given that ROM is relatively new, it may require a cultural shift in therapist attitude and behaviour (Lewis, 2012; Unsworth et al., 2012). It is likely that this practice will not be well received if it is judged to be just another line of bureaucracy, possibly even resulting in conflict if it is exclusively driven by top-down processes (Boswell et al., 2015; Unsworth et al., 2012; Wolpert, 2014). Overall, this suggests the need for greater engagement with practitioners when implementing ROM practices.

The influence of practitioners' attitudes and belief about service provision can be identified in evidence reported by Delgadillo et al. (2013). Surveying 82 psychotherapists, a majority of whom were from IAPT services, they found that

decision-making in a stepped-care approach was influenced more so by a range of idiosyncratic assumptions, perceptions and beliefs, rather than a lack of observable progress on treatment scores. These included a belief that other services would not accept a referral promptly enough, leading to a detrimental impact on a client's condition. Another important factor was forming a strong therapeutic alliance with a client. This pattern appeared to be less prominent in those delivering low-intensity treatments, which Delgadillo et al. (2013) consider being the result of stricter case-management, although the numbers were too small to compare groups adequately. These findings also support similar trends using more in-depth qualitative techniques (n=24) (Gellatly, 2011) and mixed-methods based approaches (n=42) (Lucock et al., 2015). This suggests that practitioners may not fully recognise the usefulness of ROM in treatment. That said, it could also be due to a lack of appropriate space for self-reflective practice, something that IAPT practitioners have reported is difficult in light of time and service pressures (Haarhoff, Thwaites & Bennett- Levy, 2015).

For the implementation of stepped-care, it is likely that ROM could be beneficial, although those who devalue its usefulness might lead to difficulties for themselves, others and their clients.

Given their diagnostic basis and symptom counting features, there are some who criticise the particular use of these measures within IAPT services as further encouraging a biomedical view of CMHPs (Loewenthal, 2015; Marziller & Hall, 2009; Rizq, 2012a). It is important to remember that in general, the diagnostic criteria for determining a CMHP can be problematic (Bentall, 2004; Dowrick, 2004), especially since diagnosis recording can be poor within IAPT services due to incomplete data (Böhnke et al., 2014; Clark et al., 2009; Glover et al., 2010). Similarly, given the high rate of comorbidity between CMHPs, a disorder-specific measure will encompass some significant limitations (Budd & Hughes, 2009; Dowrick, 2004; Glover et al., 2010; McManus et al., 2009). Additionally, it introduces and reinforces a type of language that could impact on client engagement for those who do not identify with such terminology. Furthermore, by their very content, these measures tend to favour a CBT-based approach in tackling symptomology, reflecting a more positivist stance by attempting to be objective, even though they are inherently subjective. As previously discussed, many other

social factors can influence a client's mental wellbeing beyond therapy (see Implementation Science - The Socio-Demographics of Mental Health p.25). What's more, this will likely be inappropriately reflected in short, diagnosis and symptom-orientated outcome measures; therefore, making their usefulness for gaining knowledge about service effectiveness limited.

The use of short, multi-dimensional outcome measures in IAPT services is supported by evidence that indicates each one provides a unique disorder-specific domain for assessing the nature of someone's mental health (Böhnke et al., 2014). However, the format is important to consider, as evidence suggests that data collected via a telephone or face-to-face is not comparable for certain tools, such as the Generalised Anxiety Disorder 7-Item Scale (GAD-7) measure (Ryan, Bailey, Fearon & King, 2013; Spitzer, Kroenke, Williams & Lowe, 2006). Moreover, the Work and Social Adjustment Scale (WSAS) (Mundt, Marks, Shear & Griest, 2002) evaluates other unique domains relating to wellbeing and social functioning, however the interventions used in IAPT services appear to only ever produce small effect sizes on this measure (Hammond et al., 2012). What's more, for over 90% of clients the WSAS has been reportedly difficult to administer in the initial assessment session (Glover et al., 2010). Comparatively, the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) provides a robust tool that can contextualise a client's difficulties at intake and discharge (Rao, Hendry & Watson, 2010), with it also being frequently used in third-sector services. Nevertheless, beyond the IAPT demonstration sites its use has not been made compulsory, likely due to a poor completion rate (Clark et al., 2009). With these factors in mind, there may be some concerns regarding the reductionist nature of ROM in IAPT services.

Looking directly at the IAPT programme's published outcomes reveal a high level of variation between sites and general underperformance concerning targets (Glover et al., 2010; HSCIC, 2014a, 2014b; IAPT, 2012; RCP, 2013). The latest annual figures report recovery rates varying between 24% to 71% across all Clinical Commissioning Groups (CCGs) (HSCIC, 2014a). Similarly, the practices of aggregating data, calculating effect size and defining outcome were found to vary widely between first-wave IAPT sites (Delgadillo et al., 2014a), something that will likely follow in the full-scale rollout.

How IAPT services calculate their recovery rate has already been explained (see Routine Outcome Monitoring within IAPT Services p.56). This calculation, although simple and easy to use, encourages a potentially adverse incentive, as clients with larger scores are less likely to cross the clinical threshold, making it advantageous to 'cherry-pick' those who are on the borderline, and by definition, less complex. Analyses of IAPT services confirm this as higher initial treatment scores can lead to a decreased recovery rate overall (Goddard et al., 2015; Green et al., 2015; Griffiths & Griffiths, 2015; Gyani et al., 2011); this being around 15% lower for depression and anxiety than compared with the national average (n=25,034) (Griffiths & Griffiths, 2015). Subsequently, recent developments have started to report on an actual shift in scores, above measurement error (Clark, 2014; Jacobson & Truax, 1991); however, the previous calculation still remains in use.

These are important considerations as the sector moves towards Payment by Results (PbR) in which commissioning seeks to reimburse services according to their recovery rate. Notably, qualitative evidence from commissioners highlight a possible issue in this regard, as the use of brief outcome measures, which were only supposed to be indicative of identifying symptoms, are now increasingly being used (or misused) to judge service effectiveness, ultimately having a bearing on the goals, financing and survival of services (Griffiths, Foster, Steen & Pietroni, 2013).

The sample chosen can hugely alter the overall recovery rate, therefore defining what is meant by treatment effectiveness is crucial (Glover et al., 2010; Griffiths & Steen, 2013a; Stiles et al., 2006, 2008). Analysing IAPT service data reveals a high proportion of clients fail to make it into treatment (Griffiths & Steen, 2013a; HSCIC, 2014a, 2014b; Richards & Borglin, 2011; Stanton, 2012). There is also evidence to suggest those entering IAPT services are not representative of their catchment area (Brown et al., 2014; Delgadillo et al., 2014b). By considering the number of people entering treatment, similar to an intention-to-treat sample, the overall recovery rate decreases substantially (Glover et al., 2010; Griffiths & Steen, 2013a); however, this interpretation remains limited by an absence of paired scores. Consequently, not including these clients runs the risk of misconstruing service efficiency, as it appears more effective than it really is by only representing a subset of clients (Callan & Fry,

2012; Glover et al., 2010; Griffiths & Steen, 2013a; Stanton, 2012), thus distorting reality (Rizq, 2012a).

Rizq (2011, 2012a, 2013) provides a series of papers that critiques the current emphasis on clinical governance within IAPT services, as well as other issues relating to its consumerist ethos and minimising discourse regarding psychological distress. Rizq contends that the constant need to perform ROM and concentrate on a series of relatively optimistic targets ultimately leads to practitioners dehumanising and losing interest in clients, creating a somewhat instrumental view of the human condition. For this reason, targets are privileged over the desire to care, with a neoliberal and market-driven rationale underpinning service provision. Rizq then goes on to argue that doubt, guilt or concerns about the delivery model is effectively silenced in the face of externally validated policies and outcomes, creating a perverse defence mechanism, where treatment scores are used to justify inadequacies in service provision. It may also lead to reduced autonomy in practitioners, creating tensions in practice and possible burnout (Steel et al., 2015; Walklet & Percy, 2014). Consequently, it may be that practitioners feel powerless in ever questioning the use of ROM; instead opting to complete them despite being aware of their perceived flaws (Rizq, 2012b).

From the client's perspective, it is important to engage with outcome measures in a meaningful and respectful manner as clients may feel passive or uninvolved in the process (Eliacin, Salyers, Kukla & Matthias, 2015; RCP, 2013; Vail et al., 2012). Equally important is overcoming social, language and cultural barriers (Rao et al., 2010), implementing suitable adjustments to assist the client in their understanding and involvement (Costa & Briggs, 2014; IAPT, 2008c; Jamieson & White, 2008; Watts & Robjant, 2008). Additionally, the abundance of outcome measures used within IAPT services could be influenced by demand characteristics, or fatigue and practice effects, though the impact of these factors might only be small (Boswell et al., 2015; McCambridge et al., 2012). If not used sensitively, these measures could have a detrimental impact on the therapy and therapeutic encounter (Boswell et al., 2015; Wolpert, 2014). Therefore, for this approach to be successful, the system ought to be designed with the clients' best interest in mind.

3.6 Practitioner Experiences

3.6.1 Exploring Practitioner Experience within a Newly Established Psychotherapy Programme

Understanding the implementation process requires exploring the behaviour of those closely involved in delivering and implementing treatment, namely practitioners working within IAPT services. The IAPT programme regards the development of excellence in its workforce to be key in the implementation of services (IAPT, 2008d). Therefore, it is important to consider the IAPT delivery model and its effect on experiences to understand which factors are influential in the successful uptake and integration of EBPIs. It is certainly true that the IAPT programme represents one of the biggest shifts in the provision of psychological therapies within primary care to date, with its clear delivery model, implementation strategy and government support. Significantly, the unprecedented levels of funding attached to the initiative sets it in direct contrast to the provision that preceded it; itself characterised by long waiting lists and poor and unequal access (Layard et al., 2007; McManus et al., 2009; Mind, 2014). Much of the work is closely regulated and monitored using close case management and ROM that feeds back into auditing, performance management, service quality improvement and cost recuperation practices. A substantial proportion of treatment is provided by low-intensity therapists, also known as Psychological Wellbeing Practitioners (PWPs), who tend to deliver a manualised version of a particular therapeutic model. Consequently, these practitioners can be trained in relatively quick succession and mobilised to deliver treatment fast, exponentially growing the size of the workforce and client output (IAPT, 2012). Simultaneously, the programme's central team controls the implementation strategy and training regime to permit a more systematic and accelerated approach to service dissemination. While the new found commitment and recognition from central government is likely a welcome development, the pressure accompanying this initiative could have an impact on daily work activities.

A key thing to remember is that all these factors contribute to maintaining the programme's successful dissemination (McHugh & Barlow, 2010; Seward & Clark, 2010), allowing for it to develop, refine and update its approaches. Nevertheless, all

these aspects have a bearing on the implementation process and are therefore worth considering. Moreover, implementation represents a mostly social endeavour of balancing and negotiating the demands of multiple agents within a context of finite resources (Damschroder et al., 2009; May & Finch, 2009). The huge shift in delivery, together with the limited guidance that is available for the local adaptation of services, separates out this stage within the IAPT programme as being of notable interest and importance, particularly around the impact on practitioner experience.

3.6.2 The Characteristics of IAPT Work

One of the defining characteristics of the IAPT delivery model is in its high-volume, low contact style provision, running counter to the traditional low-volume, high contact delivery in other psychotherapeutic models. Subsequently, the pressures and means to see an increasingly high number of clients has an impact on conventional provision and will, therefore, be expected to have an impact on practitioner experience and behaviour. Drawing on case study examples, Rizq (2011, 2012b) illustrates how the pursuit of targets, high-volume working and overly optimistic terminology can lead to tensions in IAPT practitioners for whom the clinical reality is very different. Indeed, the impact of high-volume working and lack of autonomy have been linked with feelings of emotional exhaustion and lower satisfaction in employment, potentially leading to greater staff turnover (Moreea, 2015; Rizq, 2012b; Steel et al., 2015; Walklet & Percy, 2014). Consequently, this aspect of provision may be difficult to accommodate for, particularly for those who prefer working more intensely with clients.

The source of strain may be born out of pursuing unrealistic targets as a result of being based on what some have characterised are naïve and idealistic assumptions (Marziller & Hall, 2009; Pietroni et al., 2012; Moloney, 2013; Williams, 2015). Chief among these is the economic argument and bold claims that much of a client's condition can be set right solely by investing in psychotherapy when in fact the problem is often multifaceted and context dependent. What's more, the original argument on which the programme is based, into what has been implemented, has several notable discrepancies. Most prominently, as Cooper (2009) rightly points out, despite the original proposal arguing for 10,000 newly trained therapists, ambitions

of the programme still remained high when in fact the true figure was closer to 3,600. Barrett (2009) and Rizq (2012a) argue that the conceptual basis on which the IAPT programme is founded, namely its economic and neoliberal ideology, contradicts the platform for dependency and relatedness, replacing it instead with clients who are ultimately depersonalised and perceived as though they are a utility for the service. Additionally, these authors argue that the pressures on practitioners limit the time available for sufficient exploration of a client's issues, with the model instead encouraging quicker throughput. Accordingly, the means by which to adequately treat a client is distorted, with less contact and faster output in delivery misunderstood as producing equivalent outcomes to more intense and holistic therapeutic provision. For this reason, practitioners could feel strained and conflicted in response to these seemingly unfounded assumptions.

Not only might these targets be difficult to achieve but they may also impact on the therapeutic relationship, rapport and levels of patience with incoming clients (Rizq, 2012a). These are important concepts as they can influence the provision of stepped-care (Delgadillo et al., 2013), thus impacting on service efficiency. Indeed, despite evidence supporting a greater use of stepping-up for improving outcomes (Glover et al., 2010; Gyani et al., 2011; Radhakrishnan et al., 2013), together with the use of guidance and ROM, practitioners can still be reluctant to commit to this process (Boswell et al., 2015; Delgadillo et al., 2013; Richards et al., 2012). Perhaps this is due to forming a strong therapeutic bond (Delgadillo et al., 2013). Consequently, this highlights a potential clash in practitioners who may feel as though they have a connection with a client but are required to move them on in light of pressures from the service, as well as feeling under constant scrutiny and surveillance through regulation and monitoring. Moreover, the high-volume, quick throughput nature of IAPT-style provision might further impact on this process and the formation of a therapeutic bond, leading to an increased disconnect between practitioner and client.

As already stated, much of the IAPT delivery model constitutes a greater proportion of low-intensity treatments, which are themselves characterised by the use of treatment manuals and close case management. Certainly, given their clear structure and formulation, many of these interventions are suitable for delivery by non-specialists (Bennett-Levy et al., 2010). Moreover, the use of manualised approaches

has been found to reduce the impact of therapist variance (Ali et al., 2014; Almlöv et al., 2011), leading to more equitable access and standardised training. Conversely, additional evidence has found the influence of a therapist to be still just as important as it is in high-intensity treatment (6% to 9%) (Firth et al., 2015; Green et al., 2014). Significantly, the use of these manuals can be limited by their modality specificity (Duncan & Miller, 2006), leading to constraints in provision.

In its early stages at least, IAPT services made use of a relatively inexperienced and newly trained workforce (Rizq, 2011) who even after training, might be left feeling initially unskilled (Bogart, 2015; Rizq, 2011; Robinson, Kellett, King & Keating, 2011). Under these circumstances, practitioners may be expected to work beyond their competency, leading to anxiety and frustration (Rizq, 2013). Indeed, the RCP (2013) national audit found evidence to suggest that a significant minority of practitioners are working with clients outside their expertise, or delivering a therapeutic model for which they have no formalised or accredited training. Comparatively, this issue appears to feature strongly in the assessment of risk, which can sometimes employ less experienced practitioners (Cairns, 2014; Di Bona et al., 2014; Mathers & Mitchell, 2010), over-the-phone techniques (Böhnke et al., 2014; Cairns, 2014; Jones et al., 2013; Vail et al., 2012), or varying approaches to risk assessment (Vail et al., 2012), possibly leading to inappropriate care and difficult working practices.

Shepherd and Rosario (2008) draw on their experiences of supervising low-intensity practitioners in the context of existing literature. Their article is essentially a case study with its rich, detailed account being useful here for consideration. They report that the limited training, which is characteristic of low-intensity work, requires added on-the-job training that is difficult to implement. They contend that it would be naïve to assume that an increase in low-intensity practitioners will be able to deal with the many complexities of mental health problems. However, the pursuit of efficiency gains may demand that services emphasise a greater proportion of low-intensity interventions. Specifically, this will be increasingly difficult with the inclusion of a self-referral pathway as the complexity of cases referring in will not be known up until a practitioner is consulting with them.

3.6.3 Implementing an IAPT Service

The successful implementation of services will require strong leadership, a focus on quality, finding the capacity required for integrating these services, plus coordinating a newly trained workforce. Certainly, over the last ten years, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) membership has more than doubled, mainly as a result of the IAPT programme being implemented (Cavanagh, 2014). Corresponding this there has been a huge growth in competency frameworks (Roth & Pilling, 2008), treatment manuals, commissioning toolkits (IAPT, 2008b, 2008c, 2008d), and a series of IAPT accredited training courses. Consequently, the expansion of IAPT services, including the growth of its workforce and accompanying materials, represent a complex and multifaceted process that practitioners will need to coordinate. Notably, practitioners will need to be mindful of the local area need in respect of treatment fidelity, a limited budget, and commissioner requests, perhaps requiring the use of incentives to encourage adequate and sustainable provision (Layard et al., 2012; McHugh & Barlow, 2010). As evidence and robust guidance are currently limited regarding the implementation process, it will be the task of practitioners to ensure that they are a recognised, effective and accreditable service worthy of further investment, both at a local and national level.

It is probable that due to the wide variation in outcomes and organisation of the delivery model between sites (Glover et al., 2010; HSCIC, 2014a, 2014b; Richards et al., 2012), practitioners' experiences will vary with it. Accordingly, the South West IAPT evaluation study reported on interview data from four different sites and found wide variation in the development of their respective delivery model, including differences in the justification for each approach (Byng et al., 2011). One issue in particular across all sites was a concern for gaps in services developing. This refers to those clients who are considered to be too severe for IAPT treatment, but not severe enough for other services. Fortunately, more direct contact and stronger links with other sectors were found to lessen the impact of this. Consequently, this may have a bearing on those services exclusively delivering treatment at one particular step as they may not be able to transfer clients promptly enough (Delgadillo et al., 2013; Hammond et al., 2012). Given that each area has a unique context and set of

circumstances, the approach and experiences to coordinating these are of interest and would benefit further investigation.

The implementation of IAPT services in primary care also means integrating them into existing services and their accompanying workforce. Accordingly, there may be tensions at this stage, particularly in the cases where groups of therapists are identified as 'non-IAPT' (Altson, Loewenthal, Galtandlis & Thomas, 2014; Lewis, 2012). The theoretical critiques that followed the programme's inception (see Theoretical Critiques on Conceptual Basis and IAPT Delivery Model p.52) also highlight possible tensions from other therapists working within this area. Robinson et al. (2011) conducted a series of semi-structured interviews, involving six mental health nurses transitioning into becoming an IAPT high-intensity therapist. Through a retrospective descriptive analysis of their experiences during their training year, one notable theme that emerged was that of forming a new identity and feeling initially unskilled. They found broad support for clinical supervision in overcoming feelings of inadequacy, but this was also dependent on the organisational context. While these findings are limited to a small number of therapists, who all engaged with the same training module, it does provide a rich, in-depth narrative on the importance of role identification and the impact of perceived competence. Significantly, it highlights the concept of belonging and practitioners having to identify themselves with the IAPT delivery model. A consequence of this could be that therapists practicing in another modality that is not recognised as being IAPT-compliant, might seek to modify their behaviour for the sake of belonging, although as evidence suggests, this might lead to greater conflict and division of the workforce (Altson et al., 2015; Lewis, 2012). Indeed, evidence has highlighted that a greater level of experience in another modality can lead to greater resistance when engaging with another approach (Altson et al., 2015; Lewis, 2012; Unsworth et al., 2012). Therefore, it seems that the process of consultation will be important to overcome feelings of resistance and possible coercion.

3.7 Client Experiences

3.7.1 The Rationale for Client Feedback and its Place within IAPT Services

Increasingly, it is being recognised throughout the NHS that to improve services, client feedback is essential (Coulter, Locock, Ziebland & Calabrese, 2014; NHS England, 2013). Many recognise client experience as having a significant contribution to make (Weinstein, 2010), either as part of the service-user movement in tackling stigma (Campbell, 2005), within mental health charities (Weinstein, 2010; Mind, 2014), being involved in the development of NICE guidelines (NICE, 2009a), redesigning IAPT services (Byng et al., 2011), or finally being involved in practitioner training (Price, 2011).

The current evidence on client experience within IAPT services is limited. Although many services boast high rates of satisfaction (Clark et al., 2009; Kuhn, 2011; IAPT, 2012), these are based on answers derived from measures that utilise brief Likert scales, with a small space for additional commenting (IAPT, 2015). Similarly, their representativeness is likely biased as those having a negative experience are less likely to respond (Di Bona et al., 2014). Indeed, one of the most pressing problems of satisfaction-based questionnaires is their consistent tendency to mainly report positive outcomes (Bee et al., 2008). Other concerns regard the fact that responses are characteristically subjective and misconstrued as objective truth (Moloney, 2013). Such factors do not do justice to the rich, in-depth nature of client experience when engaging with services.

Guy et al. (2012) argue that therapy is relational, therefore, referring to outcome scores is not meaningful without access to client narratives. Similarly, Rowland (2007) stresses the importance of more exploratory and in-depth methods for evaluating psychotherapy:

> Psychological therapies are by definition relational therapies. The therapeutic alliance between therapist and patient is an important influencing variable in terms of outcome; it tends to be best captured by qualitative research and case studies (p.28)

Exploring client experiences within IAPT services remain limited despite their recognised importance and clients' desire to become more involved in planning, feedback and service advocacy (Baddeley, 2014; Hamilton et al., 2011; Weinstein, 2010). Most research has tended to favour looking into clinical outcomes and cost-effectiveness, or exploring practitioner experiences, thus overlooking the central role of the client in therapy (Bohart & Tallman, 2010). Also, evidence suggests that drawing on narrative from other sectors may be inappropriate as those engaging with IAPT services have been found to be more optimistic (Brazier et al., 2014).

Evidence reporting on client experience within IAPT services has focused on the use particular types of therapies (Wykes, 2013; Lucock, Barber, Jones & Lovell, 2007) or how a client perceives their emotional distress and move to recovery (McEvoy, Schauman, Mansell & Morris, 2012; Baddeley, 2014; Easby, 2010). Currently, no studies exist which directly analyses the experiences of those engaging with the IAPT delivery model, particularly across multiple settings. There is some limited research which has explored how particular service innovations can impact on client experience (Byng et al., 2011; Cameron, Walker, Hart, Sadlo & Haslam, 2012; Gellatly, 2011; Hamilton et al., 2011). Each of these report complex, varied and diverse accounts, further confirming the need for qualitative inquiry to complement clinical outcome scores (Campbell, 2013).

Critiquing the evidence that is available reveals several methodological constraints. Some studies use reimbursement strategies (Baddelley, 2014; Brazier & Connell, 2014; Hamilton et al., 2011) which may impact responses, motivating participants to "tell us what he or she feels we want to know" (McKeganey, 2001, p.1237), although Head (2009) considers this to be useful for overcoming power imbalances between the participant and researcher. Other evidence has reported using multiple methods but failed to state how many participants took part in their focus groups (RCP, 2013). Elsewhere, participant recruitment is a particular concern (Hamilton et al., 2011), reflecting the wider issues of poor recruitment in primary care research (Bower et al., 2009). Finally, those involved tend to include people who are only available during business hours (9-5pm) leaving a proportion of client experiences unknown (Baddeley, 2014; McEvoy et al., 2012).

3.7.2 The Stages Leading up to Service Engagement

The decision to seek help for a CMHP can be difficult and potentially anxiety-inducing (Anderson & Brownlie, 2011; Evans-Lacko et al., 2013). Approaching services can be fraught with uncertainty, having implications for service provision and assessment (Spratt & Carey, 2009). Evidence suggests that help-seeking among these individuals is poor, with many in denial and opting to deal with their issues on their own (Anderson & Brownlie, 2011; McManus et al., 2009). Individuals may be anxious about stigmatising attitudes (Evans-Lacko et al., 2013) leading to concealment or fear of disclosure about their condition (Barnes, 2011; Cameron et al., 2012; Vogel, Wade & Ascheman, 2009). This stigma may be then internalised, having an impact on their attitude, behaviour and approach towards a service (Barnes et al., 2013). Therefore, this may lead to conditions worsening, making them harder to treat.

A client's awareness about services might be poor (Hamilton et al., 2011) as might a GP's (Gyani et al., 2012; RCP, 2013). The promotion of others may be helpful in boosting service engagement such as the enthusiastic promotion of GPs or entry staff (Bennett-Levy et al., 2010; Marks & Cavanagh, 2009). Ultimately, clients will have to wait to access treatment, but it is important that this time is reduced by as much as possible (Delgadillo et al., 2013). Equally, clients referring in will demand clear communication strategies, especially during prolonged waits, to offset feelings of anxiety (Hamilton et al., 2011). Clients may also seek to access a service via another healthcare sector, either through a dual pathway (Firth-Lewis et al., 2013) or collaborative care model (Knowles et al., 2013).

Additionally, qualitative evidence supports the idea that clients want to regain their independence and not feel as though they are a burden on others (Brazier & Connell, 2014). Clients may be accessing services as they are fearful that their welfare payments will be taken away (Barrett, 2009), or feel guilt and self-blame for not retaining employment (Cameron et al., 2012). Likewise, the cost of therapy is an important factor in accessing services (Anderson & Brownlie, 2011), making their provision on the NHS valuable and likely appreciated (Hamilton et al., 2011). Talking therapies can be a preferable intervention for clients when treating CMHPs

(Duncan et al., 2010; McHugh et al., 2013), suggesting access to them should be positive and welcomed.

Individual characteristics can also play a role in the lead up to service engagement. Moreover, those with more complex, longer lasting and comorbid conditions will also likely be familiar with mental health services, hence their approach towards accessing treatment will be different (Cairns, 2014; Di Bona et al., 2014; RCP, 2013). In spite of this, a client's history of CMHPs is not routinely collected in IAPT services, even though a substantial minority of sufferers are at risk of relapsing, according to epidemiological studies (Buckman, 2014; King et al., 2008). What's more, a service area's casemix is important in this regard considering the many socio-demographic factors influencing mental wellbeing (Black, 2008; Marmot et al., 2010; Wilkinson & Pickett, 2009). Consequently, there is more additional data needed about these influences, including how they might impact on engagement.

3.7.3 Entering and Engaging with Services

A client may hold several expectations and negative preconceptions about a service that could influence their approach and overall engagement, though this can be quickly overcome during the initial period (Bee et al., 2008; Easby, 2010; Hamilton et al., 2011; Turner, 2015). Entering a service can be characterised by increased emotional vulnerability, shame, guilt and confusion, requiring a certain degree of courage (Wolpert, 2014). The high rate of attrition in IAPT services (Glover et al., 2010; Griffiths & Steen, 2013a; HSCIC, 2014a, 2014b), with the highest occurring during the early stages (Richards & Borglin, 2011; RCP, 2013), could also be linked to the type of delivery model implemented (Byng et al., 2011; Di Bona et al., 2014). It suggests that many referring clients who do not feel comfortable with the model may find it difficult to raise an issue about it (RCP, 2013). What's more, during prolonged waiting times, clients may also feel isolated and overlooked (Byng et al., 2011; Hamilton et al., 2011; RCP, 2013). Ensuring there is clear communication between the client and practitioner in the interim may help to reduce this (Easby, 2010; Hamilton et al., 2011; RCP, 2013).

The processes of negotiating treatment and decision-making may be difficult if a client is uncertain or tentative. Aside from treatment type, choice of intervention should also consider gender, timing and location (RCP, 2013). According to the RCP (2013), 16% of clients engaging with services did not feel as though they received enough information regarding therapist gender (n=174). Elsewhere, Vail et al., (2012) have raised concerns about clients not being as involved in the decision-making process as much as they should (Vail et al., 2012; Buckingham, Ahmed & Adams, 2013). Furthermore, the level of desired involvement with clients can vary during their engagement, being dependent on context, individual characteristics and timing (Easby, 2010; Eliacin et al., 2015). Consequently, these issues will need to be addressed during the delivery and implementation of services or risk alienating and disengaging clients.

The means by which an intervention is portrayed can make a difference, as perceiving something as secondary to the 'real thing' will impact on its uptake (MacDonald, Mead, Bower, Richards & Lovell, 2007; Pimm, 2015), particularly regarding low-intensity interventions (Bennett-Levy et al., 2010). Therefore, this highlights the critical role of language and relational working. Accordingly, therapeutic rapport can help with engagement and outcomes (Khan, Bower & Rogers, 2007), possibly influencing the rate of dropout (RCP, 2013), enhancing a client's sense of control, leading to positive outcomes (Hamilton et al., 2011; Westra, Aviram, Barnes & Angus, 2010) and positive experiences (Barnes et al., 2013), all of which the accompanying IAPT policy documentation advocates (Turpin & Fonagy, 2010).

Another important aspect involves a process of identifying with a service, as clients attempt to make sense of their experience by contemplating or judging how the service, therapist and intervention relate to them personally (Badelley, 2014; Hamilton et al., 2011; Khan et al., 2007). MacDonald et al. (2007) reported a discrepancy in clients (n=24) engaging with low-intensity interventions which prioritise symptom resolution over a genuine desire to uncover insight and explanation about their condition. Equally, Barnes et al. (2013) found tensions among clients who felt their past and current issues were not being explored or considered highly enough within a CBT-orientated approach (n=26). Indeed, not all

aspects of CBT are always liked, but those that stick with it tend to focus on features that they do like (Barnes et al., 2013; Beattie, Shaw, Kaur & Kessler, 2009). Equally, client opinion can differ regarding the use of diagnostic labelling with some warming to the idea, while others consider them to be depersonalising or inappropriate (Badelley, 2014; Hamilton et al., 2011; Scott, 2010). Therapy can be a confusing, upsetting and sensitive process where clients are required to confront difficult and negative issues which, although some clients consider necessary for recovery (Barnes et al., 2013; Easby, 2010; Hayes, Laurenceau, Feldman, Strauss & Cardaciotto, 2007), may increase the likelihood of disengagement if they do not feel safe and comforted (Barnes et al., 2013; Di Bona et al., 2014). Consequently, the current approach adopted by IAPT services could be difficult for certain clients to embrace and affiliate with.

Engaging with a service requires a certain level of time commitment, the impact of which could influence engagement (Price, 2011). Short protocol driven therapy can be helpful, even preferable for clients in terms of convenience, comprehensibility and ease of use (Easby, 2010; Kenwright, 2008; Mansell, 2007). However, some may find them patronising, too simple and not relevant (Easby, 2010; Lucock et al., 2007; Mansell, 2007). Additionally, more chronic and complex conditions will require more practitioner input (Thomas & Drake, 2012). Generally speaking, the perception of receiving scripted or 'textbook' therapy is not desirable (Badelley, 2014; Hamilton et al., 2011), as aspects of the relationship may feel devalued when perceiving the practitioner as rigid and working within a predetermined manual (Hamilton et al., 2011; Richardson et al., 2010). Similarly, it is important to be flexible regarding the duration of therapy and respond to client narratives (Hamilton et al., 2011; RCP, 2013). Having said this, the RCP (2013) found that 15% of clients (n=14,587) did not feel that they had the right number of sessions, but were not comfortable speaking about this with their therapist, highlighting potential challenges regarding demand characteristics.

The format for therapy is crucial, particularly regarding over-the-phone therapy for which opinions vary, some preferring its convenience and anonymity (Kenwright, 2009), while others prefer facial contact (Marks & Cavanagh, 2009; Waller & Gilbody, 2009). Hamilton et al. (2011) reported that clients expressed concern

regarding over-the-phone therapy perceiving it as providing a lack of depth. Likewise, a phone allows clients to disengage more readily by hanging up. Despite initial expectations being poor (Badelley, 2014; Brenes, Ingram & Danhauer, 2011; Easby, 2010; Eliacin et al., 2015), there is evidence to support its applicability in IAPT services (Hammond et al., 2012), yielding positive experiences (Lovell, 2010), and relieving pressure on waiting times and other therapists (Chan & Adams, 2014; Delgadillo et al., 2014b; Hammond et al., 2012). Nevertheless, this format still has its limitations and may be linked to re-referral (Cairns, 2014; Di Bona et al., 2014; Ryan et al., 2013). What's more, practitioner resistance may also influence treatment decisions (Richards et al., 2006; Richardson, Richards & Barkham, 2010). In any case, the IAPT programme is moving forward on over-the-phone therapy as a means to enhance access. Consequently, understanding the experiences of engaging with this format in IAPT settings is worthy of further investigation.

Integral to the IAPT delivery model is ROM. Although its use may be helpful in focusing therapy (Wolpert, 2014), writing things down could still present a risk regarding fear of being judged by those who read it, or feel guilty if they fail to complete it (Barnes et al., 2013; Price, 2011). Also, clients may be uncertain about how the information is stored or used (RCP, 2013), or concerned that scores do not adequately reflect their understanding of distress and recovery (Brazier & Connell, 2014), leading to feelings of confusion and possible anxiety.

With respect to the service setting, providing a welcoming atmosphere and accessible location with approachable staff, who can listen and respect clients, will likely produce positive experiences (Hamilton et al., 2011; Weinstein, 2010, p.213). Where appropriate, reasonable adjustments should be made for clients who have language and mobility difficulties. This will require making adjustments for people with learning difficulties (Chinn, Abraham, Burke & Davies, 2014; Shankland & Dagnan, 2015; Dodd, Joyce, Nixon, Jennison & Heneage, 2011; Kirk, Sehmi, Hazeldine, Palmer & Ruddle, 2013), adapting materials in a sensitive and culturally appropriate way (Watts & Robjant, 2008), plus greater community engagement (Jamieson & White, 2008; Watts & Robjant, 2008). Ultimately, the evidence is limited, but the use of an interpreter could be useful in this aspect of client engagement (Bassey & Melluish, 2012, 2013; Costa & Briggs, 2014; Mofrad & Webster, 2012).

Finally, the role of others may influence a client's experience of service engagement (Badelley, 2014), with acceptance and support of the family being crucial (Weinstein, 2010). Moreover, the support and recognition of others might motivate clients to stay engaged (Brazier & Connell, 2014). Nevertheless, involving the family in the therapy session or in the course of treatment has proven difficult in light of therapist attitude and limited accommodation (Shepherd, 2014), suggesting this could be an issue during the implementation process.

3.7.4 Leaving the Service and Life Beyond Therapy

Understandably, longer-term work will influence the end of therapy and pace of discharge (Thomas & Drake, 2012). Hopefully, during their time with an IAPT service, a client may be able to consider themselves recovered or more enabled. However, defining recovery is not always agreed upon and can be difficult for clients to determine (Barnes, 2011; Barnes et al., 2013; Carey, Mansell & Tai, 2015; Pilgrim, 2009). It is also important to remember that the method by which IAPT services calculate their recovery can be a source of dispute (see Current Limitations in ROM and their Place within the IAPT Framework p.60). Nevertheless, there is evidence emerging about how a client receiving treatment in IAPT services perceives their recovery (Beattie et al., 2009; Brazier & Connell, 2014; Gellatly, 2011; Hamilton et al., 2011). Tentatively, evidence has pointed to the concept of recovery as being a dynamic process that gradually builds and enhances resilience and self-efficacy, leading to the development of a new identity (McEvoy et al., 2012). Consequently, the concept of mental illness and move to recovery among clients can differ (Barnes, 2011; Carey et al., 2015; Campbell, 2013; Gellatly, 2011; Weinstein, 2010, p.201). Recovery can be a long and complicated process depending on a client's condition, severity and chronicity (Brazier & Connell, 2014). Recovery ought to be about focusing on the strengths and identity of the client, rather than on their symptoms as a 'patient' (Weinstein, 2010, p.210). Instead, recovery can be thought of as an ability to cope, gain control and live life despite ongoing difficulties concerning mental health, situational constraints and a possibly chaotic lifestyle (McEvoy et al., 2012).

Finding employment may also help in sustaining outcomes (Black, 2008). IAPT services are unique as they also assess their re-employment rates, which could likely influence the subject matter (Wesson & Gould, 2010). Its inclusion could be therapeutically beneficial, so long as it is not coercive (Hogarth et al., 2013; Wesson & Gould, 2010). Elsewhere, the use of employment link workers has been associated with improved employment outcomes and higher rates of satisfaction from representative samples (Cameron et al., 2012; Hogarth et al., 2013).

Beyond treatment completion, it will be useful to seek formal feedback as there are some who wish to make their experiences known, exposing valuable insight, although receiving this feedback is not always feasible (Hamilton et al., 2011; RCP, 2013). Significantly, a perceived lack of anonymity about their responses may impact on a client's ability to feedback (RCP, 2013). Accordingly, the basis for follow-up appears to be well grounded in research, policy advocacy and client demand; however, its implementation in services is not always possible or routinely used (Byng et al., 2011; Hamilton et al., 2011; Turpin & Wheeler, 2011). The evidence that is available suggests that a follow-up procedure communicates the service as being more caring, interested and available, leading clients to feel less isolated (Hamilton et al., 2011; RCP, 2013). Furthermore, the basis for a follow-up is useful for establishing whether IAPT services provide sustainable outcomes (Cairns, 2014; Di Bona et al., 2014). That said, there is an obvious risk of losing contact with clients between these stages (Clark et al., 2009), thus having implications on service efficiency. Likewise, those that relapse may not wish to re-refer if their treatment is deemed to be ineffective. Buckman (2014) found that the presence of residual symptoms, or having received a higher number of sessions, were a useful indicator for identifying clients at risk of re-referring, although this may solely be a proxy for more severe conditions. In any case, following up on clients could potentially serve a number of benefits, though the evidence remains limited.

3.8 Summary and Implications for Research

The IAPT programme is currently the main vehicle for treatment in the provision of psychological therapies in primary care (DH, 2011a). It is supported by central government because it offers the potential to reduce individual suffering, increasing

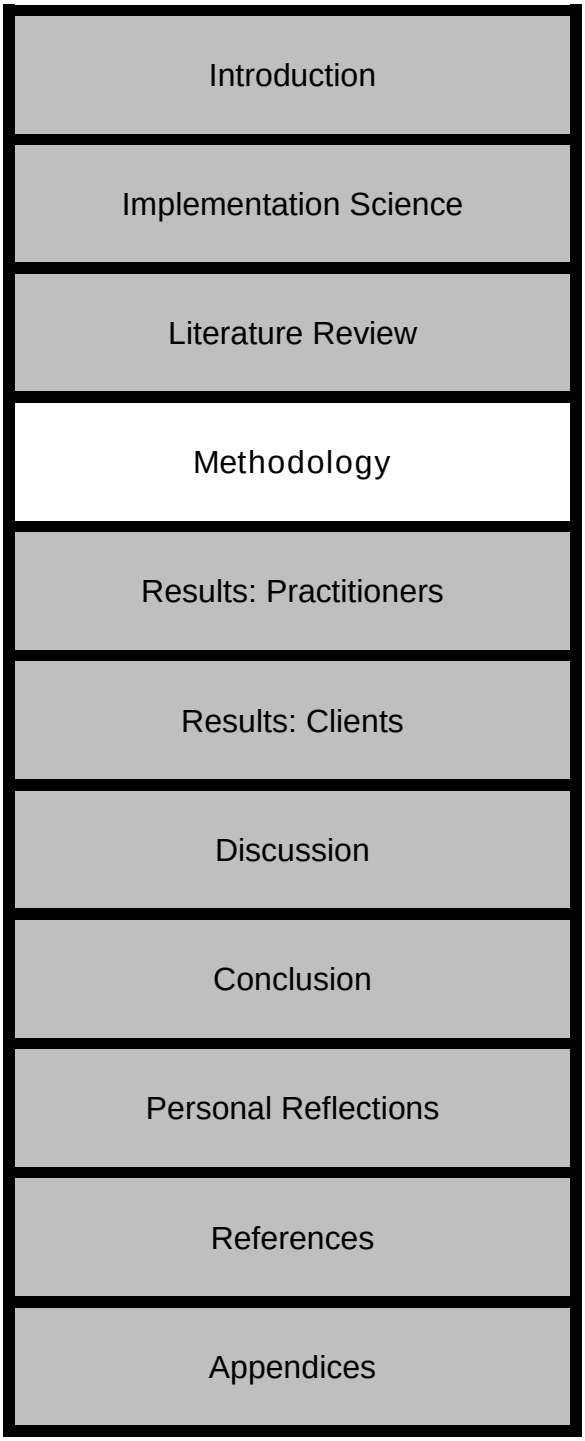
economic gains through reduced work absenteeism, welfare payments and inpatient healthcare costs. Therefore, its breadth and coverage mark it out as being an important area for research.

Despite the many achievements of the programme, there are many prominent issues regarding its performance. Overall, it is still achieving access and recovery rates below that which is expected and targeted for (HSCIC, 2014a, 2014b; IAPT, 2012; RCP, 2013). Subsequently, recent data reports that access rate targets, on average, were achieved, although with considerable effort and wide variation in the figures (Dormon, 2015). Regarding access, engagement, attrition and recovery rates, figures have been found to vary widely between services (Glover et al., 2010; HSCIC, 2014a, 2014b; IAPT, 2012; Richards & Borglin, 2011). The insights into explaining this variation remain limited to the interpretation of raw outcome measures or isolated service evaluations. In brief, the current range in outcome scores only offers partial insight into a larger narrative concerning the provision and implementation of services.

Many interventions found to be effective in research trials fail to translate into meaningful outcomes in clinical practice across multiple settings (Damschroder et al., 2009; Eccles & Mittman, 2006; Proctor et al., 2009; Shafran et al., 2009). One approach to understanding this phenomenon has been to focus on the implementation process itself (Eccles et al., 2009; May & Finch, 2009). Focusing the attention here could potentially bridge the "quality chasm" of research into clinical practice (Institute of Medicine, 2001, p.1). Currently, understanding the process for implementing an IAPT service remains limited. Understanding how its delivery model is routinely embedded and integrated into practice is important for health professionals, managers, researchers and policy-makers alike. Furthermore, investigating the decision-making processes used during local implementation offers the greatest opportunity for the effective translation of evidence-based practice (Barkham, et al., 2010; Evans et al., 2013; McEvoy et al., 2014). Consequently, this thesis will explore and evaluate the experiences of practitioners delivering and implementing services.

In parallel, this thesis will draw on the experiences of those engaging with services as each account is unique and can offer new insights and perspectives (McEvoy et al., 2014; Smith et al., 2013). Client experience is increasingly being used throughout the NHS in an attempt to improve services (Coulter et al., 2014). The NHS operating framework 2012/13 expressly states that services should routinely collect and use this experience for service quality improvement (DH, 2011b). These initiatives will enable the NHS to develop services that build around individuals rather than clients being made to fit a particular model. They are often the most overlooked in psychotherapy research, despite their important role and valuable insight (Bohart & Tallman, 2010). Furthermore, there is limited research analysing client experience for engaging with the IAPT delivery model.

There is some evidence emerging which has focused on the implementation process of IAPT services, although much of this has failed to capture the experiences of those attempting to deliver and implement a service fully. Likewise, the evidence is limited regarding the experiences of clients engaging with this unique delivery model; itself characterised by a fast access, high-volume throughput. Similarly, the use of ROM can only provide part of the narrative regarding this process. Given the multiple factors that can influence a client's journey in primary care, understanding this process will have implications for practice and future implementation strategies.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

4 Methodology

4.1 Overview

In this chapter, I will consider the focus of my research project and the methodological techniques that are best suited to achieve the aims and objectives of this thesis. The basis for discussion will be to consider the chosen methodological framework: Interpretative Phenomenological Analysis (IPA) (Smith et al., 2013); together with the format for data collection: semi-structured interviewing. Also discussed is the use of two separate conceptual frameworks, including the Patient Pathway (Department of Health (DH), 2007) and the Normalisation Process Theory (NPT) (May et al., 2010). The study recruited two small homogenous samples for interviewing, with the chapter divided to reflect this. The process for recruitment, analysis and reporting for each group are also presented, along with ethical considerations.

4.2 Aims

- To explore, identify and analyse the implementation process involved in establishing and delivering an Improving Access to Psychological Therapies (IAPT) service.
- To uncover the factors that either facilitate or impede its development to provide a more in-depth and detailed account of the implementation and operation of services.
- To develop an understanding regarding the applicability of evidence-based practice and the IAPT delivery model in a clinical setting, for the provision of psychological therapies.

4.3 Objectives

- To explore the experiences of those implementing, managing and providing treatment within their service.
- To investigate the means by which the IAPT delivery model is embedded and integrated into practice.

- To report on and evaluate client experiences of engaging with the IAPT delivery model.

4.4 Research Questions

- What factors influence the successful uptake and integration of the IAPT delivery model?
- How do those delivering services experience the implementation process?
- What factors are influential in the experiences of clients during service engagement?

4.5 Type of Methodology

The two primary areas of methodological inquiry are quantitative and qualitative. A quantitative approach searches for facts and objective truth, utilising statistical data to reject the null hypothesis and verify theories via deductive logic (Robson, 2011). A qualitative based approach favours the search for meaning and understanding process, thus requiring the use of interview techniques or language based analyses, typically via inductive logic (Savin-Baden & Major, 2013). The core characteristics of qualitative research have more or less remained the same throughout the years (Creswell, 2013; Savin-Baden & Major, 2013). It focuses on exploring and attempting to capture an individual's thoughts, feelings and interpretations through a detailed, rich and complex analysis (Hiles, 2008; Ormston, Spencer, Barnard & Snape, 2013; Savin-Baden & Major, 2013). The analysis identifies patterns and themes in the data, identifying meaning in consideration of the research goals (Braun & Clarke, 2006). Their application affords the investigator the ability to explore meaning and process within the lived experience of the individual. It, therefore, holds the possibility of discovery and generating new insight (McLeod, 2011; Savin-Baden & Major, 2013; Smith, Flowers & Larkin, 2013), becoming an essential tool in identifying, exploring and understanding the implementation process (McEvoy et al., 2014).

The IAPT programme is about providing equitable access to Evidence-Based Psychotherapeutic Interventions (EBPIs) as recommended by the National Institute

for Health and Care Excellence (NICE) guidance (Clark, 2011). However, a critique levied at NICE and thus the IAPT programme, is its close affiliation with the biomedical model, embracing a positivist, or post-positivist approach to knowledge (Guy et al., 2012; Marziller & Hall, 2009; Williams, 2015). This position, although recognising the role of the investigator in the research process, still favours and assumes that a "knowledge claim" can be obtained objectively, by utilising quantitative methods (Creswell, 2003, p.6). While this approach is useful, it has been critiqued in its application to the field of psychotherapeutic research for being too reductionist (Guy et al., 2012; Loewenthal, 2015; Mollon, 2009; Pietroni et al., 2012). The source of this critique is born out of the reliance and preference for more controlled methodologies, such as the Randomised Controlled Trial (RCT) (Kendall, Pilling, Whittington, Pettinari & Burbeck, 2005; NICE, 2009a). It has been argued that the characteristics defining these approaches do not adequately reflect the realities of a real-world clinical setting (Guy et al., 2012; McPherson, Evans & Richardson, 2009). Accordingly, these concerns have led to the pursuit of alternative methods by embracing a practice-based evidence approach, including the use of less controlled, exploratory methods. These approaches aim to use real-world data, positioning the investigation as close to clinical reality as possible, equally recognising the value of the client, carer and practitioner perspectives'.

4.5.1 Methodological Pluralism

An alternative paradigm that is emerging in social science research is the pursuit of methodological pluralism (McLeod, 2011; Barkham et al., 2010). This approach attempts to integrate several complementary sources of evidence to produce a more holistic understanding. On balance, all methodological approaches have their strengths and weaknesses (Robson, 2011). In recognising this, it is useful to consider broader and varied methods of inquiry. This research is a not multi-methods study per se, although its basis stems from some of its guiding principles.

The principles of positivism/post-positivism are contingent on quantifiable observation, leading to methods of observation and statistical analyses. It is currently the dominant approach to evaluating IAPT services. However, understanding the experiences and processes involved in the implementation and operation of services

requires the use of exploratory and in-depth techniques (Atkins, Smith, Kelly, Michie, 2013; McEvoy et al., 2014; Palinkas et al., 2013). Implementation is understood as a continual, social and relational process along multiple levels (May & Finch, 2009; Palinkas et al., 2013) making cross-sectional analysis problematic and in-depth, detailed analysis preferable. Researchers adopting a qualitative methodology tend to define their approach in opposition to the underlying principles of the positivist position, or are at least perceived to do so (Ormston et al., 2013). Alternatively, the pursuit of methodological pluralism and practice-based evidence seeks to emphasise these perspectives as complementary and not in opposition (Barkham et al., 2010). Similarly, a multi-perspective approach can be used to develop a detailed and multifaceted account of phenomena (May & Finch, 2009; McEvoy et al., 2014; Smith et al., 2013). A complementary strengths standpoint acknowledges the philosophical assumptions of different approaches as distinct and complementary (Greene, 2006), so long as the method honours each standpoint and their differences are made explicit (Moran-Ellis et al., 2006).

4.5.2 Epistemological Position

Following this logic, I considered the research philosophy of pragmatism for which the role of knowledge and meaning is found in its usefulness for action (Goldkuhl, 2012). However, given that the IAPT programme is already fully embedded into practice, understanding these processes and experiences requires an approach that directly explores phenomena already in action, since it is not in a position to implement change. Instead, I considered an interpretivist/constructionist position to be adequate for the research aims. In these paradigms, knowledge of the world is constructed and negotiated between human beings through social interaction and relationships. According to social constructionism, in the act of knowing the individuals actively ascribe meaning and order to a reality from which they are responding (Robson, 2011; Savin-Baden & Major, 2013). It recognises that meaning, significance and understanding are co-constructed with other human beings, not separately or objectively. It informs an idiographic, hermeneutic approach that is best explored using qualitative methods with the focus on how individuals make sense of their experiences and place meaning upon them (Robson, 2011). Implementation is constructed through human systems and social interaction, aligning well with this

standpoint. I also felt that my interpretations and feelings about the data should be acknowledged due to the subjectivity involved in using qualitative techniques. Larkin, Watts and Clifton (2006) argue that it is never truly possible for one to remove themselves, their thoughts and interpretations of meaning from the world and the research process. Therefore, appreciating and recognising the role of the investigator in the analysis of data is important. Thus, I considered this position to be advantageous as it embraces the role of the analyst rather than deny their influence. Lastly, quantitative data collected and published by the programme is used to contextualise the data and further expand on the constructions of meaning.

4.5.3 Methodological Framework: Interpretative Phenomenological Analysis

The primary focus of this thesis is to explore and understand the implementation process of the IAPT delivery model at a micro-level, while also considering the influence of meso- and macro-processes (Griffiths, 2003). Data collection involves drawing on the experiences of practitioners delivering and implementing services, as well as those who have engaged with a service. To ensure the translation and trustworthiness of the data are enhanced, the use of a methodological framework and coding system are warranted. This framework should be systematic, logical, transparent and sensitive to context (Biggerstaff & Thompson, 2008; Hsieh & Shannon, 2005; Yardley, 2000, 2008).

IPA focuses on "personal meaning and sense-making in a particular context, for people who share a particular experience" (Smith et al., 2013, p.45). It is a qualitative, phenomenological and hermeneutic approach that explores how people make sense of their experiences and the meanings they attach to them (Finlay, 2012; Larkin et al., 2006; Smith et al., 2013). The approach can be used to re-evaluate a particular phenomenon, inform the understanding of novel or under-researched areas, as well as inform and contextualise existing quantitative data (Larkin & Thompson, 2012). It is a contemporary methodological approach, grounded in psychology, that draws on the research philosophies and theoretical concepts of phenomenology, hermeneutics and idiography (Finlay, 2009, 2012; Smith et al., 2013).

4.5.3.1 Phenomenology

Phenomenology is a research philosophy that involves exploring and understanding the lived experience of individuals, focusing on a distinct experiential perspective (Finlay, 2012; Savin-Baden & Major, 2013). The lived experience of a person is revealed by how they perceive and make sense of an event, process or object (Finlay, 2012). The approach has its origins in the work of Husserl, who emphasises the importance and relevance of focusing on human experience and its perception, rather than the formulation of an objective account (Smith et al., 2013). Later developing this work, Heidegger, a student and admirer of Husserl's, introduced a hermeneutic perspective to the philosophy of phenomenology, diverging from Husserl's teachings and incorporating an ontological dimension regarding existence itself. Heidegger conceived that our being in the world emerges in the experience of our everyday existence, and thus requires focusing on how the world is perceived and made meaningful. Other philosophers developing Husserl's work further include Merleau-Ponty, who conceived individual experience as being personal and embodied within the world, arguing that no two people can ever fully share in the other's experience. Another philosopher of note is Sartre, who, similar to Heidegger, emphasised the role of action and meaning making, conceiving the self as continually developing. These philosophers in their individual and unique way shifted from the descriptive leanings of Husserl towards a more interpretative position, recognising the individual as immersed and embedded within a world of people, things, relationships, language and culture, rather than in isolation (Smith et al., 2013).

4.5.3.2 Integrating Hermeneutics

In IPA research, the investigator attempts to gain, as Conrad (1987 as cited in Smith et al., 2013, p.36) terms it, an "insider's perspective" by exploring how individuals make sense of the world and their relationship to it. IPA also emphasises a pluralistic approach, drawing on the philosophy of hermeneutics: the theory of interpretation (Rennie, 2012; Smith et al., 2013). Hermeneutics is broadly influenced by the work of Heidegger, who emphasises the hermeneutic aspect of phenomenological analysis (Smith et al., 2013). While phenomenology seeks to explore and uncover meaning, hermeneutics interprets this meaning (Rennie, 2012). It is the central role of the

analyst to facilitate and make sense of how the phenomena emerge (Smith et al., 2013). In this regard, it is recognised that all inquiries start with the analyst's perspective, something that may be influenced by prior experiences (Larkin et al., 2006). Rather than setting these preconceptions aside in advance, the analyst is encouraged to adopt a "sensitive and responsive" approach that allows their preconceptions to be adjusted by the data (Larkin et al., 2006, p.108; Smith et al., 2013). Here, a reflective practice is crucial as one may not be aware of their preconceptions in advance of the analysis (Finlay, 2009; Pietkiewicz & Smith, 2014; Smith et al., 2013). Smith et al. (2013) emphasise the "positive processes of engaging with the participant more than the process of bracketing prior concerns… the former inevitably facilitates that latter" (p.35), highlighting the continuous and engaging nature of this activity.

Qualitative research often makes use of inductive logic in which the analyst puts aside, or brackets, prior experiences or knowledge (Finlay, 2009; Ormston et al., 2013; Pringle, Hendry & McLafferty, 2011). However, there are some who question whether this is possible or even desirable (Blaikie, 2007; Finlay, 2009). Heidegger expressed phenomenology as being an interpretative activity, hence it is likely the biases and attitude of the analyst could influence the process of bracketing. Therefore, this leads to the proviso that bracketing must be undertaken as a dynamic and cyclical process, which may only ever be partially achievable (Smith et al., 2013). Blaikie (2007) argues that there is no such thing as 'pure' induction or deduction, such that inductive researchers will always generate and interpret their data based on assumptions made deductively from prior work in the field. Considering this, I have opted to make use of a reflexive diary to bring into awareness my preconceptions (Biggerstaff & Thompson, 2008; Chan, Fung & Chien, 2013; Finlay, 2008; Pringle et al., 2011). Other necessary steps will involve adopting an open-ended, passionate and not-knowing stance towards participant responses (Chan et al., 2013), so as to discover new and valuable insight.

In IPA, the analyst is trying to make sense of the participant's attempt to make sense of their world (Larkin et al., 2006; Smith et al., 2013). Accordingly, this represents a double hermeneutic, or two-stage interpretation process (Larkin et al., 2006; Pietkiewicz & Smith, 2014; Smith et al., 2013). It highlights the dual role of the

investigator who is combining phenomenological insights, as reported by the participant, and hermeneutic insight, as interpreted by the analyst (Smith et al., 2013). Additionally, the hermeneutic circle describes the dynamic relationship between the whole and its constituent parts, with both the whole and the part understood in connection with one another (Larkin et al., 2006; Smith et al., 2013). In this sense, the part may only manifest in the context of the whole, and vice versa. This further identifies the iterative process and cyclical nature of the analytical process in IPA, with meaning analysed at multiple levels.

4.5.3.3 Idiography

Idiographic inquiry is another theoretical influence on IPA and is an approach that considers the particular and distinct experiences of individuals and the context in which they occur (Smith et al., 2013). As a result, the analysis must be rigorous and systematic with each narrative assessed in isolation through dynamic bracketing (Smith et al., 2013). The final stage attempts to gather general themes from all respondents, while also remaining faithful to the individual (Smith & Eatough, 2006). Highlighting and appreciating the uniqueness of personal experiences, in conjunction with the shared experience, is a hallmark of the IPA approach (Smith et al., 2013). The logic follows that small sample sizes are recommended for IPA research to allow for more in-depth analysis and "do justice to the complexity of human psychology itself" (Smith et al., 2013 p.38). The participants are purposively selected and homogenous in their experiences regarding the phenomena of interest. Smith et al. (2013) do not prescribe a sample size ideal, instead stressing the importance of quality, not quantity. Brocki and Wearden (2006) conducted a critical review of IPA sample sizes and found the range to be between one to 35. An average sample size of published studies using IPA seems to be continuing this trend (Robinson, 2014). As a whole, I find privileging the role of the individual to be well suited to the scope of this research as it attempts to uncover distinct and meaningful experiences.

4.5.3.4 IPA Critiqued

In discussing and critiquing various data collection methods across a range of IPA studies, Brocki and Weardon (2006) highlight that researchers often fail to report and consider the advantages and disadvantages of its approach. Pringle, Drummond, Lafferty and Hendry (2011) discuss and critique IPA with respect to other phenomenological analyses, and their arguments are useful here for consideration. They point out that one of the intended uses of IPA was to make qualitative analysis more accessible. Indeed, the series of steps outlined by Smith et al. (2013) appears to make things more coherent and easier to follow than other qualitative methods. However, it is the use of these steps that has been subject to criticism for being too rigid, limiting the exploratory utility of qualitative analysis. Nevertheless, Smith et al. (2013) advise that these steps should be used merely as guidelines, avoiding a rigid and prescriptive approach. Furthermore, I do not consider the individual processes outlined in the IPA framework to be rigid or prescriptive; instead, they are noticeably flexible and exploratory in their nature. The cyclical, dynamic and nonlinear procedure outlined in the approach are no more prescriptive than how other qualitative analyses are undertaken. Significantly, the advantage of an IPA approach is that it offers an auditable and transparent process that seeks to operationalise the analyst in data collection (Pringle et al., 2011). For me, it is this reason that IPA is preferable as it recognises the active role of the analyst, encouraging them to consider their biases and interpretations in the analytical process carefully, thus taking a more reflexive approach (Finlay, 2008; Pringle et al., 2011; Smith et al., 2013). Similarly, one of the main advantages of IPA is that it encourages the analyst to move beyond the mere descriptive, actively seeking convergence and divergence, rather than only seeking commonalities. On balance, the series of steps that Smith et al. (2013) provide are useful for critical analysis and moving beyond the analyst's perceptual field, hence enabling new insight.

Equally important is recognising the potential disadvantage of opting to use a small, homogenous sample. If the sample is too specific or unique, then this could have an impact on the finding's transferability for shedding light on the broader context. Pringle et al. (2011) argue that overcoming the methodological limitations requires that the researcher acknowledges and resolves these early on. It is necessary to

recognise the intended use of data for what it is. Given its limited nature, there can be little to no generalisability about the data and emergent findings. However, as Smith et al. (2013) advise, it is important to think more of the theoretical transferability rather than an empirical generalisability. It is also necessary to recognise that the research findings are not the only credible account, but part of a wider narrative which makes use of multiple methods aiming to uncover the truth. IPA is useful as it seeks out the individual experience for which many other methodological approaches do not emphasise as strongly. Therefore, ensuring the data is sufficiently linked with current literature is important although, in respect of the first point discussed above, the investigation must allow enough scope for flexibility, using the research as a guide only to direct the inquiry. Similarly, to do justice to the individual experience it is important that the narrative is rich and transparent, rooting findings firmly in the quotes and experiences of participants.

4.5.4 Considering other Qualitative Methodologies

One of the advantages of IPA is that it encourages open dialogue between the participant and interviewer, allowing certain aspects of an experience or phenomena to be observed in a new light. It not only emphasises the individual experience of participants but also recognises the role of the investigator in interpreting the data. The use of this method is increasing within the field of social science (Brocki & Wearden, 2006; Smith, 2011), including numerous studies involving IAPT services (Baddeley, 2014; Chambers, 2015; Gyani et al., 2012; Shepherd, 2014). Its idiographic nature sets it apart from other qualitative approaches such as discourse analysis or grounded theory (Finlay, 2009; Savin-Baden & Major, 2013) (see Table 4 for my comparison of key qualitative analysis frameworks in the context of this research). Furthermore, I have attended several research conferences presenting on how others have used the IPA framework in their research, further encouraging its choice for this thesis. Its emphasis and account for individual experiences are in keeping with the research aims and philosophy of this thesis. Accordingly, I consider the process to be a clear and robust method to follow, giving sufficient flexibility when analysing the data.

Table 4: Comparison of Key Qualitative Analysis Frameworks

Qualitative Methods	Philosophy	Goal	Methodology	Reject/ Accept	Rationale
Thematic Analysis (Braun & Clarke, 2006)	Thematic analysis is a method in its own right	Becoming familiar with the data, generating, defining and reviewing themes through a systematic process	Identifying, evaluating and recording themes/patterns within the data Units of meaning identified from the data	Reject	Emphasis on exploring the phenomenological world of participants is less than that of IPA, as is the recognition of the interpretive role of the investigator
Grounded Theory (Blumer, 1986; Glaser & Strauss, 1967)	Interactionist approach Individuals are known to share a culturally orientated understanding of their world, with similar attitudes and values Theory is grounded in the data	Develop explanatory level account (factors, impacts, influences, social processes, context) Analysis resulting in a new theory by examining concepts (grounded/having a direct relationship in the data)	People as self-aware Symbolic interactionism and meanings in interactions, actions and consequences Objectivist and constructivist approaches (Charmaz, 2011) How does the process happen in the context of a particular setting/environment?	Reject	Used for developing explanatory accounts Relies on larger and less homogeneous samples, giving less privilege to the individual The focus of this thesis is more interested in the experience of implementation and engaging with services, along with understanding the sense-making processes that go along with these experiences
Narrative Inquiry (Connelly & Clandinin, 1990)	What story structures do people use to describe events	Focus on how narrative relates to sense-making and interpretation of the world	Essentially a hermeneutic endeavour Data drawn from the contextualised stories that people tell to understand their actions and identity	Reject	Significant overlap with IPA (Eatough & Smith, 2008) but IPA places greater emphasis on internal 'real' subjective experiences
Discourse Analysis (Kaplan & Grabe, 2002)	How is something constructed Knowledge is constructed through interactions and multiple discourses	Focus on how things must be understood according to a setting's conventions Understand how people use language to create and enact processes and phenomena	Use range of data sources What discourses are used and how do these shape relationships, activities and identities	Reject	Less emphasis on individual lived experiences; less able to elicit a participant's story Words are not assumed to speak for themselves

Qualitative Methods	Philosophy	Goal	Methodology	Reject/ Accept	Rationale
Phenomenology (Sokolowski, 2000)	Perceived reality with common features Explores the experience and meaning of phenomena, being in that person's 'life-world'	Designed to uncover phenomena through understanding experience and meaning, revealing things that are hidden, rather than making inferences Moving beyond the mere descriptive	Understanding phenomena as a whole, using full and in-depth interpretations for what it means to them in their particular world What is the lived experience?	Accept as a component, but need to account for other aspects of inquiry	Looking to distil participants' subjective experiences Understanding phenomena, revealing things previously overlooked, although it may not always be possible to describe something without adding an interpretation at the same time, hence using IPA that explicitly recognises this and integrates it into the analysis
Interpretative Phenomenological Analysis (Smith et al., 2013)	How do people make sense of their experiences	Focus on personal meaning and sense-making in a particular context for a particular experience	Variant of phenomenology Combining an idiographic approach, focusing on an individual's cognitive, linguistic, affective and body language Using a double hermeneutic, or two-stage interpretation process	Accept	Taking all values and the role of interpretation into account Recognises and emphasises more so the unique, diverse and rich experiences of the participants Homogeneous sampling More systematic approach Recognises the central role of the investigator Deeper and more critical analysis, interpreting meaning via hermeneutics

4.6 Semi-Structured Interviewing and Developing the Interview Schedule

The format for data collection is semi-structured interviewing. This approach provides greater flexibility than a questionnaire or more structured interview format as it allows the investigator to explore and probe new areas of interest that may not have been previously considered (Robson, 2011; Savin-Baden & Major, 2013; Smith et al., 2013). Therefore, this format is suited to researching complex phenomena as it allows for a more flexible approach to data collection. Nevertheless, having an interview schedule is important so that the phenomena of interest is focused upon and explored. The interplay between inductive and deductive processes is accepted in the framework of IPA, although an inductive process is still prioritised (Chan et al., 2013). It could be argued that with the use of these frameworks, the exploratory advantage of qualitative analysis is reduced. However, focusing on concepts derived from theory can help sensitise the researcher to relevant issues, processes and interpretations that might not have been previously considered (Blaikie, 2007). In any case, ensuring the questions are open-ended will permit more exploratory analysis. Moreover, the cyclical process of bracketing, or leaving aside one's preconceptions is important in the analytical process of IPA, restricting the influence of these concepts on the interpretation of data. On balance, using theory and conceptual frameworks is helpful in guiding and structuring the focus of the interview.

4.6.1 Conceptual Frameworks

4.6.1.1 The Patient Pathway

I draw upon the conceptual framework of the patient pathway to develop the interview schedule and focus (DH, 2007). The patient pathway describes the course a client will take when engaging with a service, from referral to conclusion (DH, 2007). Richards et al. (2012) use this conceptual framework when conducting an observational study of throughput data to assess the implementation of the IAPT programme and organisation of stepped-care between sites. It conceptualises the delivery model and client's journey, teasing out the influencing factors involved in

facilitating or impacting on the implementation process. It also provides a systematic framework from which to work across interviews, with its focus in line with the research aims.

4.6.1.2 Drawing on Implementation Research Tools

Implementation research is the study of methods to promote the uptake of research findings into routine clinical practice, which includes exploring the behaviour and experiences of health professionals and key stakeholders (Eccles & Mittman, 2006; Eccles et al., 2009). This area focuses on generating evidence to inform policy and practice about context, adaptations and response to change. It uses empirical methods to interpret and understand the black box of implementation, something that service evaluations fail to capture (Stenler, 2006). Academics within implementation research advocate a multi-perspective design to understand these processes (Finch, Mair, O'Donnell, Murray & May, 2012; McEvoy et al., 2014), recognising the contribution of different agents in providing a more holistic understanding of implementation (Finch et al., 2012; May, 2013; McEvoy et al., 2014; Wagner, Rau & Lindemann, 2010). Therefore, this research seeks to understand the experiences for both those implementing and those engaging with services.

4.6.1.3 Constructing the Interview using the Normalisation Process Theory

The NPT specifically conceptualises the implementation process, focusing attention on the contributions of those routinely implementing and embedding innovations in practice (May & Finch, 2009; May et al., 2009; Murray et al., 2010) (see Implementation Science – Implementation Theories: The Normalisation Process Theory p.30). In this instance, it has been used to develop and refine the focus of the interview. Its use corresponds well with an interpretative approach and therefore, is useful for focusing the line of inquiry. The NPT is a middle-range action theory that contains four theoretical constructs (see Table 5). It does not claim to be a theory of everything or a conceptual straitjacket; instead, it is intended to act as a heuristic device for researchers to refer to at different points in the development and analysis of the research process (May et al., 2010; McEvoy et al., 2014; Murray et al., 2010). It focuses on how knowledge is held, transferred and created within groups, seeking

to understand the work and experiences of various agents (managers, clinicians and clients alike) (May & Finch, 2009). Importantly, Knowles et al. (2013) reported positive experiences and meaningful findings when using the approach for investigating the implementation of IAPT services, including their links with physical healthcare settings, thus further encouraging its usefulness for this research.

The questions and focus of the inquiry combine the core constructs of the NPT (May & Finch, 2009) with the patient pathway conceptual framework (DH, 2007) (see The Patient Pathway p.95). Utilising concepts of the patient pathway, the interview assesses factors influencing the implementation process, developing a unique and collective experiential account of how aspects of the pathway have been adapted, and what the experiences and rationale were accompanying these. Utilising concepts of the NPT, the interview explores reflexive and collective action in implementation (May & Finch, 2009). The concept of coherence, or sense-making, was integral to all forms of inquiry in the interview and resonates with the IPA approach. Questions were split according to the IPA framework for the interviews, which recommends six-10 open-ended questions, lasting around 45 minutes to one hour in duration (Smith et al., 2013).

Table 5: The NPT Core Constructs and Application in the Interview (May & Finch, 2009)

Core Construct	Brief Description	Application in the Interview
Coherence	Sense-making and meaning of the practice to agents	Understanding the rationale behind the implementation of certain practices - What is the value, benefits and importance of these? Is there a shared understanding of what needs to be done to promote service implementation and operation? How do the IAPT delivery model and conceptual basis influence the sense-making process?
Cognitive Participation	Enrolling and engaging individuals with new practice	Relational work enrolling individuals - What kind of norms exist around how the work is carried out? Is there agreement on how this gets done? What models are implemented to train and supervise the staff on the basis of the IAPT programme? How is it ensured that it is right for them and their staff? How has this had an effect on the implementation process and ongoing service development?
Collective Action	Enacting a new practice with pre-existing or established processes	Interacting with pre-existing and conventional processes – How is the resource assigned? What were the experiences of integrating the service ahead of IAPT's implementation? How does this impact on implementation? How were faith and confidence built among the staff? What were the processes for implementing routine outcome monitoring?
Reflexive Monitoring	Appraisal of new practice, how it is understood and assessed by agents	Practitioners: Appraisal work – how are actions justified? How effective or useful is the intervention and how is it determined? How is work assessed and understood? Did any of these procedures need changing, or would you have changed knowing what you know now?
		Clients: Appraisal work – what are the experiences of key points in the patient pathway? What advice should be given to new referrals? What was the most important aspect of engagement? How was the process of access, engagement and outcome understood? How does the implementation process reflect this?

4.6.2 IAPT Service Data

The IAPT programme collects a series of brief, session-to-session, patient-reported outcome measures for evaluating client progress and the alleviation of symptoms during treatment (see Literature Review - Routine Outcome Monitoring within IAPT Services p.56). By mandating a 90% data completion rate, the collection of data has improved substantially on the rates that preceded it (Clark et al., 2009; Stiles et al., 2006, 2008). Additionally, services supply other outcomes along the patient pathway regarding access and socio-demographic information. These are then used to generate several Key Performance Indicators (KPIs) which can be used to evaluate and compare IAPT services. Recovery rates are calculated by those who make a shift

in scores from above to below a clinical cut-off score, as defined by the measure (IAPT, 2011b).

These KPIs are used to contextualise participant experiences in the interpretation of the qualitative data, service profiling and cross-site comparison. KPIs include any data that can provide information on access, engagement and recovery rates. Using secondary data sources collected in and published by the programme helps to overcome issues of time and resource allocation and potentially wasteful endeavours of inquiry (Heaton, 2004). Although there have been concerns raised regarding the variability of data collection between sites (Glover et al., 2010), these rates appear to have improved (Health and Social Care Information Centre (HSCIC), 2014a, 2014b) and will be useful for reference. Accordingly, the national rates are used as a benchmark.

4.7 Interviewing Practitioners Delivering and Implementing Services

4.7.1 Context and Settings

This research involves the participation of services all commissioned by one National Health Service (NHS) Foundation Trust (FT), creating a reference point across all participating services. The FT provides primary care psychotherapeutic interventions in nine services across a diverse range of settings, as a mixture of six IAPT services and three Primary Care Mental Health Services. The latter are not considered fully-fledged IAPT services, although they incorporate many of the same underlying principles of the IAPT delivery model, such as offering NICE-approved therapies to treat people with Common Mental Health Problems (CMHPs).

All responses and analyses are set in context using statistical data that is in the public domain and collected by various bodies. All IAPT services are required to hit a 15% access rate and 50% recovery rate target, set for March 2015, although this has since been extended by a year (IAPT, 2012; NHS Constitution, 2014b). At the time of interviewing the national average access rate was 12%, and the national average recovery rate was 43% (HSCIC, 2014b). Updating this text, almost one year later,

this has risen to an estimated 15% access rate and 45% recovery rate (HSCIC, 2014a). The rollout of the programme is nearing its completion with concerns already emerging about the misapplication of IAPT funding into other healthcare sectors (Layard et al., 2012). With regards to the political landscape, the general election remains just over a year away.

4.7.2 Service Profiles

Data published by the IAPT programme, Public Health England (2015), and 2011 Census data (Office for National Statistics, 2014), each helped to develop an individual site profile. Routine outcome data collected and published by the programme was used to provide statistical data on access, engagement and outcome at a Clinical Commissioning Group (CCG) level. Secondly, Community Mental Health Profiles (Public Health England, 2015) summarised publicly available data on prevalence, at-risk groups, and available services, and are used by commissioners and providers to benchmark their progress against other areas. The 2011 UK Census data provided key demographic and population information. Finally, interview responses were used to verify this information and elaborate more on the existing context. Using this data and referring to the literature review helped to satisfy the first principle in Yardley's (2000, 2008) framework for enhancing validity in qualitative research: sensitivity to context. The other principles include commitment and rigour, transparency and coherence and impact and importance, which I discuss later in this chapter (see Interviewing Practitioners Delivering and Implementing Services: Reliability, Validity and Trustworthiness p.110).

4.7.3 History and Timing

Five of the IAPT services that agreed to participate have been operating since the first (2008/09) and second wave (2009/10) rollout phases. By the time of the interview, all services involved had been operating for at least four years. This is important, as the impact of different start-up times has been highlighted as a limiting factor in other evidence evaluating IAPT services (Byng et al., 2011; Clark et al., 2009; Glover et al., 2010). Some services will have started with a notable disadvantage, such as inheriting long waiting lists from previously decommissioned

services (Byng et al., 2011; Glover et al., 2010). However, one of the aims of this research was to explore these types of influences in greater depth to understand their impact on the implementation process and is therefore useful for comparison.

4.7.4 Ethical Considerations

Behaving ethically in research helps to protect individuals and communities from harm, both in the conduct and outcome of its process. Any research involving people introduces the potential for harm, stress, anxiety and a host of other potentially negative consequences (Robson, 2011, p.194). Ethical conduct is supported by conforming to a code or set of principles (Israel & Hay, 2006). As such, this research has drawn on a number of ethical frameworks to help provide rigour in the development of its methodology. The DH Research Governance Framework for Health and Social Care (DH, 2005) outlines a set of principles for research governance, clearly defining a participant's rights in research. Within the field of psychotherapeutic research, the British Association for Counselling and Psychotherapy (BACP) Ethical Framework (2013) can also be used to inform best research practice. Of primary consideration is upholding a participant's rights, dignity, safety and wellbeing, through methods of informed consent, confidentiality, data protection, and protecting their right to withdraw.

To enhance research integrity and governance, I have engaged in many similar studies and training modules that involved interviewing techniques ahead of this project's undertaking. In the development and data collection stages I also regularly consulted with my academic supervisors, as well as health professionals within the FT, on a bi-weekly and monthly basis, or where else was deemed necessary.

4.7.4.1 Informed Consent

"Informed consent is at the heart of ethical research" (DH, 2005, p.7) therefore, it is critical that appropriate arrangements are put in place that inform potential participants about what will be required of them and what the intended outcome of the research will be. In this study, every participant held the right to make their own decision regarding their participation. All were fully informed about what the study

involved in advance of taking part, including the research aims and procedure. They were then allowed at least 24 hours to consider their involvement, discussing and clarifying any queries they had over-the-phone ahead of their preliminary agreement. Further information was provided using written documentation including the participant information sheet (Appendix 11.2.1) and consent form (Appendix 11.4.1). Participants should not feel hesitant about raising issues, or coerced into participating, therefore in the stages immediately preceding the interview, participants were again invited to share any concerns they had, reminding them also of their right to withdraw. Finally, a written signature was obtained as proof of a participant's understanding for what the research involved and their willingness to take part.

4.7.4.2 Confidentiality and Data Protection

The researcher has a responsibility to uphold integrity in the conduct of research. This involves honouring the trust placed in the researcher and respecting a client's right to privacy. It was assumed that a principal issue for this participant group would be that of confidentiality, given the characteristics of being a small homogeneous sample. In respect of this, only one copy of the audio recordings ever existed and were never duplicated. Each recording was stored on site at University premises and locked in a secure drawer until full written transcripts had been completed. Once this had been achieved the audio recordings were then destroyed. All participants either chose or were assigned a pseudonym and all identifying information in the transcripts was removed. This is useful for reference during analysis as it also provides participants with an identity, allowing their personal narratives to be understood in greater depth and without compromising on confidentiality. Only I had access to the full transcripts throughout the whole research process, with only an external supervisor analysing extracts to check for accuracy and ensure the findings were supported by the data (see Interviewing Practitioners Delivering and Implementing Services: Reliability, Validity and Trustworthiness p.110). These transcripts were never sent electronically via email and only transported when necessary using a memory stick. These transcripts remained saved in a password protected folder to protect participants' data. It was also judged that taking these steps and communicating it to participants would be

useful in reducing any potential self-censorship and anxiety about what they might divulge.

4.7.4.3 Right to Withdraw

At multiple points, participants were informed and reminded of their right to withdraw at any time without having to give a reason for their doing so. This was communicated both verbally and in a written format on both the participant information sheet (Appendix 11.2.1) and consent form (Appendix 11.4.1) to make this explicit. This provided participants with an exit strategy should they wish to end the interview or not answer certain questions, thus re-establishing a balance in the power dynamic between the researcher and participant (BACP, 2010; Head, 2009).

4.7.4.4 Approval

This project was submitted to the University of Chester's Faculty of Health and Social Care Research Ethics Committee and gained approval from an independent team of academics, judging the research to be ethically sound (Ref: RESCRESC0713-423). The proposed length and remit of the interview questions were not considered detrimental and the use of emotionally laden language was kept to a minimum. In the case of a potential complaint being made about the research study, the contact details for an independent member of staff from the University was included on the participant information sheet (Appendix 11.2.1).

4.7.5 Recruitment Process

4.7.5.1 Research Sample

The sample design for this study was non-probabilistic and purposively selected (Robson, 2011; Palinkas et al., 2013). It is a widely used technique in both qualitative and implementation research, with a rationale to recruit information-rich participants (Palinkas et al., 2013). Those included have particular characteristics or expertise that enable a detailed exploration of the implementation process. Non-probability sampling does not involve random selection like probability sampling.

Instead, participants are selected on the subjective judgment of the researcher and are used for the purpose of exploring complex phenomena (Palinkas et al., 2013; Small, 2009). Purposive sampling recruit participants based on a known characteristic, based on their expertise and experience within the field of interest. This was chosen over other non-probability sampling techniques, such as snowball or convenience sampling, as it reduces bias towards recruiting a group based on their approachability and social connectedness (Lucas, 2014; Palinkas et al., 2013; Robson, 2011). It is a method that is often used in IPA (Brocki & Wearden, 2006; Robinson, 2014; Smith et al., 2013), recruiting individuals with expertise from whom the processes are more likely expressed (Smith et al., 2013).

4.7.5.2 Inclusion Criteria and Rationale

Getting to the essence of the implementation process requires drawing on the experiences of those delivering and implementing services. In keeping with the research aims, the perspectives of interest are at a local level. Thus, I sought to recruit the clinical and operational leads of IAPT services. These services were selected from a list of commissioned sites from one FT to ensure a consistent and measurable base. All those recruited had experienced the early inception stages of their IAPT service up until the present day. Recruitment also included primary care mental health services as their experiences of implementing this type of delivery model was considered a useful perspective, due to the treatments offered, their structure and organisation, plus their methods of auditing, each being similar to IAPT services. Likewise, they share in common the experiences of implementing a mental health service, in keeping with the homogeneity of the sample. Besides, the use of IPA emphasises the individual experience therefore, these perspectives did not impact on the analysis of fully IAPT-compliant services. Finally, in the interests of ethical considerations, participants were excluded in the cases of refusal or if I, in a prior or ongoing relationship, knew the participant.

The IPA framework involves smaller sample sizes to allow for in-depth and rich analysis (Brocki & Wearden, 2006; Smith et al., 2013). This is important for gaining new insight and giving added weight to individual experiences (Larkin & Thompson, 2012; Smith et al., 2013). A general recommendation is a sample size of around three

to six, but Smith et al. (2013) recognises that for a doctoral thesis this may be larger. As stated previously the sample size for studies involving IPA can range anywhere between one-35 (Brocki & Wearden, 2006). In light of the number of sites commissioned by the FT, a recruitment drive was enacted to recruit all nine services.

4.7.5.3 Participants

Eight people were interviewed in total (five female, three male). See Appendix 11.6 for participant characteristics or the results chapter for a further participant overview. All interviewees were White British. One interview with an IAPT site included two interviewees (at the request of the participant contacted), due to their involvement in the implementation process. Accordingly, notes and procedures were adapted to reflect this (Smith et al., 2013).

4.7.5.4 Pathway and Materials

Following ethical approval and correspondence with the participating FT, I sent a series of emails to each individual site (Appendix 11.1.1 & 11.1.2) describing the nature and purpose of the study (Savin-Baden & Major, 2013). In the interests of transparency, attached to the email were a copy of the participant information sheet (Appendix 11.2.1), consent form (Appendix 11.4.1) and the interview questions (Appendix 11.5.1). Those contacted were then invited for a phone call at a time that was convenient for them, clarifying any queries they might have, as well as judge their eligibility. Participants were then allowed at least 24 hours to consider their involvement with the study. Once agreed, a date and time were scheduled that was convenient for them in terms of their workload. Participants were selected on a first-come-first-served basis. All correspondence and interviewing occurred during business hours (9-5pm). The time from initial contact to completing the interviews took place between March and April 2014.

4.7.5.5 Not Participating

Two services were unable to participate in the interviews. One IAPT service did not reply to two separate email invitations and were not contacted further. All other

services were responsive to the initial email and did not require a follow-up contact. Another service, which was a primary care mental health service, refused to participate stating they were in a transformative position organisationally, and thus were unable to offer a time for an interview.

4.7.6 Interviews

4.7.6.1 Peer Examination

The interview questions were referred to two independent operational leads outside the area of interest, plus my two academic supervisors for feedback and comments. Similarly, an independent committee of academics from the University of Chester, involved during the ethical application process, offered their constructive feedback. All comments confirmed these questions were valuable and open enough to spark a discussion that best suited the research aims. Equally, I have previous experience interviewing and transcribing of this nature, having undertaken similar research within this field (Griffiths et al., 2013). Consequently, these methods improved my confidence and awareness about conducting an interview and recruiting participants. Overall, the ongoing interviews did not reveal any issues and the questions were not deemed necessary for revision.

4.7.6.2 Research Interview

Once participants agreed to take part they received a confirmation email. They were also sent another email one day earlier to the interview taking place to remind and confirm their willingness to participate. I also verified they would not be required to prepare for the interview. The aims, focus and nature of the study were then discussed, and all final queries answered. Consent forms were then signed in advance of the interview commencing.

The setting was at the site of each individual service for a face-to-face interview. Considering the recommendations formulated by Bryman and colleagues (2012), these settings were chosen as they are secure, private, convenient and familiar to the participant. The interview was split into eight open-ended questions as per the IPA

recommendations (Smith et al., 2013). All equipment was checked for functionality and I ensured that I was familiar with the setting in advance of making the journey (Bryman, 2012). During the interview I made use of minimal encouragers, adopted an engaging posture and sought to explore and probe participant experiences in a neutral, but curious manner, thus encouraging engagement and building rapport with the interviewee (Bryman, 2012; Robson, 2011; Smith et al., 2013). In keeping with the IPA framework, participants were treated as an expert (Larkin et al., 2006; Pringle et al., 2011; Smith et al., 2013). Interviews lasted 45 minutes to one hour in length with this being communicated to the interviewee in advance of it taking place.

After the interview, the participants were sent an email thanking them for their participation. Notes were made regarding how well it went, what emerged in the interpersonal space and whether any new ideas manifested (Biggerstaff & Thompson, 2008; Chan et al., 2013; Finlay, 2008; Smith et al., 2013). In consideration of the IPA framework, reflexive notes were made concerning my embodied responses and sense of interpretation at the time of the interview (Appendix 11.16.1) (Finlay, 2011; Pietkiewicz & Smith, 2014). Subsequently, I made reference to these in the transcribing stages to aid the analysis.

4.7.7 Data Analysis

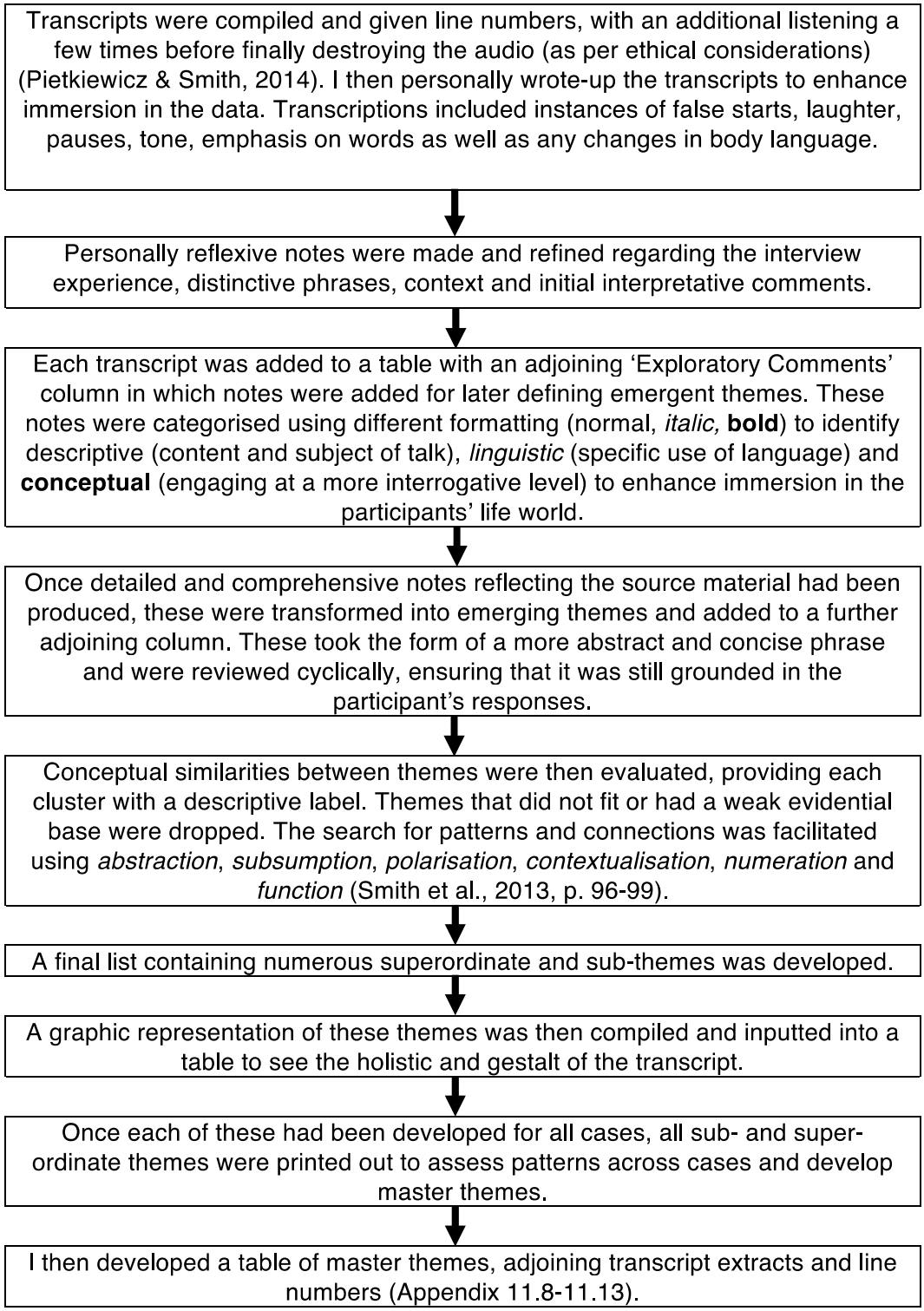
4.7.7.1 Framework

A core aspect of qualitative research is thematic analysis. This is a procedure that identifies, analyses and reports patterns or themes found within the data (Braun & Clarke, 2006). The use of analytical devices and procedures help to construct and develop the main arguments of the thesis (Gale, Heath, Cameron, Rashid & Rebwood, 2013). The outcomes of inquiry depend on various decisions made at this stage, meaning clarity and transparency are crucial. Immersion in the data, through re-reading and re-listening, over and over, affords the analysis the ability to explore phenomena both at a specific and holistic level, fostering a deeper approach to analysis (Savin-Baden & Major, 2013). The IPA framework requires a robust, iterative and cyclical procedure through a process of phenomenology and hermeneutics (Pietkiewicz & Smith, 2014; Smith et al., 2013). It advocates an

individual, case-by-case study design, involving a procedure of classifying, organising and summarising themes, usually diagrammatically or in a tabular format. As a final step, cross-case analysis identifies and explores master themes (Smith et al., 2013). The process requires a reflexive and open approach that seeks to gain higher levels of interpretation, with emerging findings firmly grounded in the words of participants (Finlay, 2008; Savin-Baden & Major, 2013; Smith et al., 2013). Consequently, it is known to be a complex and time-consuming endeavour (Gale et al., 2013; Pringle et al., 2011; Smith et al., 2013). According to Braun and Clarke (2006), the application and flexibility of the IPA procedure can be limited. However, it is by no means a rigid process. Instead, it encourages multiple levels of interpretation and creativity that balances the flexibility of an exploratory approach and systematic inquiry in respect of the research aims.

Individual interviews were analysed on a case-by-case basis. Subsequent to, and during analysis, I bracketed my interpretations in response to the emerging findings so that this insight did not interfere with the ongoing analysis. Therefore, this approach helps to preserve the uniqueness of each participant's experience (Finlay, 2008, 2012). A reflexive research diary was used periodically to record the analytical process, identifying any positional statements that could have influenced the interpretative process (Brocki & Wearden, 2006). Throughout, the analytical process was guided by the procedure set by Smith et al. (2013, p.79-107) (see Figure 5).

Figure 5: The Analytical Process of IPA Following Guidelines set by Smith et al. (2013)



4.7.7.2 Reliability, Validity and Trustworthiness

The expectations for all forms of data collection require that an appropriate level of rigour has been undertaken to enhance validity and quality of the research findings (Biggerstaff & Thompson, 2008; Hsieh & Shannon, 2005; Yardley, 2000, 2008). The very nature of non-standardisation methods in qualitative research precludes formal reliability testing, posing a potential issue (Robson, 2011). Ensuring the appropriate rigour in qualitative analysis is important and therefore, requires that approaches are adapted to enhance the finding's trustworthiness. Contemporary academics have sought to distance the qualitative method from the entanglements of positivist terminology (Robson, 2011). Sandelowski (1993) argues against concepts of "truth" or "value" for validity, claiming instead that for qualitative approaches it is about "trustworthiness" that "becomes a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable" (p.2). Lincoln and Guba (1985 cited in Lincoln, Lynham & Guba, 2011) developed constructs believed to be more appropriate to help conceptualise ways of improving the trustworthiness of qualitative research. These are credibility (internal validity), transferability (external validity/generalisability), dependability (reliability) and confirmability (objectivity). Consequently, this is considered a gold standard of criteria for enhancing the trustworthiness of research findings in qualitative research (Savin-Baden & Major, 2013), thus was reflected upon throughout the research process.

The quality of the research process was also enhanced by drawing on a range of contemporary criteria presented by Savin-Baden and Major (2013, p.476-478). These were applied at different stages based upon the needs of the research process and include: methodological coherence (ensuring congruence between the research question, methods, data and analytical processes); experience over time (staying in the field for an extended period of time, revisiting sites to enhance exposure); triangulation (cross-examination at multiple points, revisiting the data, over and over, and conferring with other academics); audit trail (description of the entire research process to retrace steps or important events that may have some influence on the findings, such as the use of a research journal); peer examination/external audit (external supervision to check accuracy and ensure findings and interpretations are

supported by the data, in this case employing the help of my academic supervisors to judge a random selection of extracts); and negative case analysis (actively seeking out data that does not support or contradicts findings and interpretations, encouraging critical thinking and refinement).

Member checking was not used as this technique contradicts many of the underlying philosophies of interpretivism and potentially invites avenues for self-censorship, halo effects and recall and timing interference (McConell-Henry, Chapman & Francis, 2011). Instead, clarification was gained during the interview rather than in a follow-up. Other methods included that of probing, paraphrasing, appreciating silence and using broad, open-ended questions (Bryman, 2012; McConell-Henry et al., 2011; Robson, 2011; Smith et al., 2013). In the interests of ethical considerations, participants were fully informed of this ahead of the interview.

The IPA framework provides a rigorous model through in-depth thematic analysis, interpretation, refinement and clear auditing processes, which considers the validity and reliability of findings to be very important (Smith et al., 2013). Smith et al. (2013) make explicit reference to Yardley's (2000) framework for assessing the quality of qualitative research, detailing how each can be informed using IPA. The framework includes: sensitivity to context (achieved through ongoing immersion and reflexive notes); commitment and rigour (achieved through investment of time, thoroughness and in-depth analysis); transparency and coherence (congruent to the principles of phenomenological and hermeneutic sensibility); and impact and importance (ensuring the outcome is interesting, important or useful). Another procedure advocated by Smith et al. (2013) is the use of an independent audit of the interpretative process and analysis to verify the findings are grounded in the data by evaluating the analytical trail (similar to the peer examination/external audit criteria of Savin-Baden & Major, 2013). Finally, I engaged with a range of papers that consider the potential pitfalls of engaging with the IPA approach, along with how to overcome them (see IPA Critiqued p.91) (Hayton, 2009; Pietkiewicz & Smith, 2014; Pringle et al., 2011; Smith et al., 2011).

4.8 Interviewing Clients

4.8.1 Context and Settings

The second part of this research project explores the lived experiences of clients who have had some experience with engaging with one of the IAPT services included in the first part of this project. All services had agreed to be contacted again to consider their involvement in this part of the research and subsequently emailed to request their collaboration and participation (Appendix 11.1.2). There was a time delay between these two stages due to an unforeseen issue in acquiring additional ethical approval from the NHS. The time elapsed between the final interviews with each service up until being re-contacted was two months. This delay, unfortunately, influenced the ongoing participation of certain services. One service chose not to participate as all their efforts were now focused on reaching the national targets (discussed earlier, see Interviewing Practitioners Delivering and Implementing Services: Context and Settings p.99). Another service was reluctant to take part due to their uncertainty about approaching and interviewing clients. One of the primary care mental health services chose not to participate due to the size of their service, and it was mutually agreed that the research aims of exploring IAPT engagement would not be achieved. After interviewing the other primary care mental health service, it became apparent that their delivery model was identical to other IAPT services regarding commissioning, outcome monitoring and treatments provided, hence were invited to participate. However, no participants were eventually recruited from this service. All other services agreed to participate, resulting in three IAPT services overall.

Other IAPT services, outside of those already interviewed were not subsequently approached. It was deemed feasible and sufficient to recruit participants across the sites agreeing to participate, due to the emphasis on small homogeneous sampling methods recommended in IPA (Smith et al., 2013). Each site profile was revisited before commencing the research process as per Yardley's (2000, 2008) sensitivity to context criteria.

4.8.2 Ethical Considerations

Given that the client group is characteristically different to those delivering and implementing services, this will require a separate section discussing the different ethical considerations. As before the DH Research Governance Framework for Health and Social Care (2005) and BACP Ethical Framework (BACP, 2013) were consulted for guidance. Many of the same procedures regarding informed consent, confidentiality, data protection, and right to withdraw were re-enacted (see Interviewing Practitioners Delivering and Implementing Services: Ethical Considerations p.101). However, it is recognised that this sample represents a potentially vulnerable group, meaning certain approaches were altered to ensure the minimisation of harm.

4.8.2.1 Informed Consent

Therapists working within the IAPT services approached all potential participants, meaning the decision to make the first contact was left up to clients. This approach was considered useful for valuing a participant's autonomy and communicating this to them. The inclusion criteria for this study required that all participants were not engaged in therapy so as not to interfere with their treatment. Informing participants followed a similar procedure as the first participant group, including being allowed at least 24 hours to consider their involvement.

There is a risk in research involving individuals who have engaged in mental health services as they might not be able to give consent on their own behalf, lacking the capacity to do so. The Mental Capacity Act 2005 safeguards these individuals by inviting participants to consult with someone such as a carer, should their capacity to give consent be effected. Given the IAPT programme's inclusion criteria to treat individuals with mild-to-moderate CMHPs, this was judged to be less of a risk. The programme also implements several specialist services for individuals whose capacity may be impacted by a learning disability (Chinn et al., 2014; IAPT, 2009) meaning this would likely be flagged up. Incidentally, all participants in this study retained their right to give consent on their own behalf.

In the event of poor practice being disclosed, a strategy was in place to contact the FT. In the case of exceptional circumstances, where the responses revealed the health and safety of others were at risk or when the law required the information passing on, this would be done in a judicious and timely manner. The participant was informed of this before undertaking the interview using both verbal and written communication, including using the participant information sheet (Appendix 11.2.2). Although it may have impacted on an individual's openness, the safety of them and others was considered paramount. Again, participants were invited to discuss any queries or concerns they had immediately ahead of the interview commencing. A written signature was then obtained on the consent form (Appendix 11.4.2) confirming that participants had understood these conditions and were happy to take part.

4.8.2.2 Confidentiality and Data Protection

The procedure for ensuring that participant data remain confidential included a similar process as was used in the previous participant group. Given the sensitive topic and stigmatising attitudes surrounding mental healthcare, it can be difficult for individuals to be open and honest about the nature of their engagement with a psychotherapy service (Anderson & Brownlie, 2011; Evans-Lacko et al., 2013; Mind, 2013). Therefore, certain extra measures were put in place in respect of a participant's contact information. This research involved the help of several IAPT services so that I would not have access to any personal details ahead of them contacting me. Once potential participants expressed an interest, their contact information were stored in a password protected folder on a University computer and all correspondence was made using a University phone line. These details were destroyed 30 days after the interview had taken place to allow a sufficient time for any ongoing discussion that may have been necessary. No identifiable contact information, including names, was attached to the transcripts, instead only being identifiable by their pseudonyms. Again, all transcripts had any identifiable information removed, and this was made explicit to participants to allay any remaining doubts.

4.8.2.3 Right to Withdraw

I re-applied the same procedure as before for communicating with participants about their right to withdraw. This technique was considered to be especially important for rebalancing the interview power dynamic (BACP, 2010; Head, 2009).

4.8.2.4 Potential Harms or Benefits

It is increasingly being recommended that clients are closely involved in the design of research studies (DH, 2005). In advance of designing and undertaking this study, I met and consulted with an independent mental health advocacy service that is closely involved with those who have engaged with NHS mental health services. They provided advice and comments on the nature and structure of the interview questions in consideration of the research aims. As such, the interview questions kept the use of emotionally laden language to a minimum, and all information was presented in an easy-to-read and understandable format. The interview questions specifically avoided topics about a participants' mental health status, remaining solely focused on their time with a service.

Interviews were arranged to take place in a secure setting close to where participants requested, to limit the burden of travel and reduce the stress of the journey. Similarly, all travel was reimbursed upon request, pending proof of receipt, to help reduce the financial burden of taking part, thus ensuring fairer sampling. Locations included their IAPT service premises or council building (public library, local mental health charity), within a privately booked room, to boost feelings of familiarity and safety.

4.8.2.5 Approval

The change in the participant group required approval from two separate research ethics committees. The first was the University of Chester's Faculty of Health and Social Care Research Ethics Committee, who judged the application favourably and granted approval (Ref: S-HSC021013-R). External ethical approval from the NHS was granted approval by the National Research Ethics Service Committee North

West, who gave a favourable review (Ref: 14/NW/0295). I also consulted with a University data compliance officer, my academic supervisors and health professionals from the FT, on a bi-weekly and monthly basis, or where else was deemed necessary.

4.8.3 Recruitment Process

4.8.3.1 Research Sample and Inclusion and Exclusion criteria

The sample design for this study was non-probability and purposive sampling (discussed previously, see Interviewing Practitioners Delivering and Implementing Services: Research Sample p.103). Therefore, the inclusion and exclusion criteria emulates the referral process of individual sites. Accessing an IAPT service requires that people be registered with a General Practitioner (GP), have experienced mild, moderate or severe depression or anxiety disorder symptoms, as well as being over the age of 16 years old. People who experience complex symptoms associated with severe mental illnesses, bipolar disorders, severe personality disorders, eating disorders, indicate a high risk of harm to themselves and/or others, have been unresponsive to multiple treatments previously, are receiving ongoing secondary care treatment, or are engaged in dependent drinking patterns and/or using illicit substances, were excluded from this study. The study employed an interpreter where necessary in the interests of fair sampling. Finally, in light of ethical considerations and research focus, participants were not invited for an interview if they were currently engaged in their therapy or were under the age of 18 years old.

4.8.3.2 Rationale for Obtaining Client Experiences

Client experience is increasingly being used throughout the NHS in an attempt to improve services (Coulter et al., 2014; DH, 2011b; Harding, Pettinari, Brown, Hayward & Taylor, 2011). The inclusion of client experience and advocacy in policy development is evident in the growth and success of UK mental health charities such as Mind (2010) and the Sainsbury Centre for Mental Health (2005). Worldwide, they are increasingly being involved in the planning, provision and evaluation of mental health services (Thornicroft & Tansella, 2005). The NPT also advocates a multi-

perspective design, including the contribution of client perspectives, recognising the contribution of different agents in providing a more holistic understanding of implementation (Finch et al., 2012; May, 2013; McEvoy et al., 2014; Wagner, Rau & Lindemann, 2010). Thornicroft and Tansella (2005) argue that "service users have vital contributions to make" in evaluating the operation of services and are "an essential aspect of the range of expertise" (p.2). Therefore, their experiences were considered valuable for the broad scope of this research.

4.8.3.3 Pathways and Materials

I met and consulted with each site that agreed to participate and discussed a plan for recruitment. Each site acted as a gatekeeper for the investigation, and it was jointly agreed that study materials were to be handed out by individual therapists in every discharge pack over a period of 3 months (June-August 2014). The materials included an advertisement sheet describing the study requirements with a reply form attached, including a 'consent to be contacted' clause (Appendix 11.3). Those interested could express their interest by calling the contact details of the University of Chester where I was based, hand in a completed reply form to the individual IAPT site, or post the reply form to the University. I also attended three separate client support group meetings to announce orally and advertise the research study in the intervals. Another avenue for recruitment was advertising the research study in client support group forums with the help of local third sector organisations in an effort to recruit those with experience of NHS services. However, this method did not prove fruitful. Recruitment in general was considered to be a particularly difficult process. These methods, although introducing a level of bias by only recruiting those who make the effort to participate, was necessary to ensure minimal distress came to those who did not want to be contacted further.

4.8.3.4 Participants

The study interviewed seven people in total (six female, one male). See Appendix 11.6 for participant characteristics or the results chapter for a further participant overview. All interviewees were White British except one female who described her ethnicity as British Asian. This female participant required the use of a female Urdu

speaking interpreter for the interview session. Notes and procedures were adapted to reflect this (Smith et al., 2013). One participant had received high-intensity treatment, with all others having received low-intensity treatments. One participant had yet to engage with their therapy due to a prolonged access to the service. In satisfying the ethical considerations, it was made sure that this participant was not currently engaged in treatment and that they were able to give informed consent. One participant was not invited for an interview as it became clear that they were currently engaged in therapy and thus would not fit the inclusion criteria.

4.8.4 Conducting the Interviews

4.8.4.1 Peer Examination

As already discussed (see Interviewing Clients: Ethical Considerations p.113-116) the research consulted with an independent mental health advocacy service that closely involves clients who have engaged with NHS services. Their comments helped refine and guide the question set, as did the guidance of my academic supervisors and individual IAPT sites. Similarly, two independent research ethics committees confirmed the eligibility of the question set and focus of the interview (the University of Chester and NHS Research Ethics Committee). Robson (2011) highlights that more flexible research methods, such as the one chosen here, can adapt the inquiry according to the responses from participants, testing out which questions do or do not work. In any case, the interviews did not reveal any issues emerging from the questions and were therefore not considered necessary for revision.

4.8.4.2 The Interview Process

Once I had received a response and interest from a potential participant, they were then contacted either via email, post or phone, at a convenient time, depending on their stated preferences on the attached reply form. Similarly, interviewees were also offered the opportunity to be conducted at any time, in respect of the format and venue restrictions. In the end, all interviews were conducted during business hours (9-5pm) in light of participant requests and negotiation.

The correspondence served as an opportunity to discuss the study in more detail, including clarification of the research aims, what would be required if they agreed to take part, as well as their right to withdraw should they wish to do so. If the participant was responsive to this and met the inclusion criteria, they were then asked for an email or postal address to read and review the participant information sheet, consent form and interview questions (Appendix 11.2.1, 11.4.2 & 11.5.2). Those who received a postal copy also received a stamped envelope to return the consent form or bring it along to the interview session. Participants were allowed at least 24 hours to consider their involvement with the study after receiving this information.

Once all final agreements had been obtained I discussed whether they would prefer a face-to-face or over-the-phone interview, with all participants requesting a face-to-face interview. Following this, I hired several different venues, which provided a private room booking close to where the participant requested. All settings were chosen for their privacy, security, convenience and familiarity to the participant (Bryman, 2012). The venues included IAPT service sites, a participant's local library and a local mental health charity. Some IAPT sites could not supply a room booking for the interview, hence booking other venues. Notes were made to reflect this difference in settings for the analytical process. Participants were reimbursed for their travel, pending a proof of receipt, and this was discussed with them ahead of the interview. Only one participant required being reimbursed for their travel.

Once participants had agreed to take part they received a confirmation email or phone call. They also received another email or phone call one day earlier to the interview taking place to remind them and confirm their willingness to participate. It was confirmed that they would not be required to prepare for the interview. In advance of the interview commencing the aims, focus and nature of the study were discussed, and all final queries answered. Consent forms were then signed before the interview if they had not already been signed. Participants were put at ease by reinforcing the message that there are no right or wrong answers, any questions could be revisited, and that they would be able to withdraw at any point in the interview, without having to give a reason for doing so. Equally, building rapport was considered important to rebalance the power dynamic (Bryman, 2012; Robson, 2011;

Smith et al., 2013). Participants were consulted several times throughout the interview on the pace and nature of the discussion and reflect on whether they were happy to continue. The participants were treated as an expert, in keeping with the IPA framework, in which I actively explored their experiences in a neutral, but curious manner (Larkin et al., 2006; Pietkiewicz & Smith, 2014; Pringle et al., 2011; Smith et al., 2013).

4.8.4.3 The Interview Schedule

Interview questions were split into nine open-ended questions, as per IPA recommendations for semi-structured interviewing (Smith et al., 2013). The purpose was to explore the participants' lived experience of engaging with the IAPT delivery model, informed by the patient pathway conceptual framework and the NPT constructs. Therefore, questions focused on the areas of referral, engagement and outcome, as well as a reflexive component (Appendix 11.5.2). Other areas of interest were concerned with identifying first-person accounts and sense-making activities of the therapeutic process, relationship, personalisation and control.

All interviews lasted around 40 minutes to 1 hour in duration. The same procedure used in the previous study with the practitioner group, regarding engagement, rapport building and reflexive notes, were re-applied here. A final email or letter was sent thanking the participants for their time. As before, post-interview notes were made about my embodied responses and sense of interpretation at the time of the interview, which helped in the analytical process (Appendix 11.16.2) (Finlay, 2011; Pietkiewicz & Smith, 2014).

4.8.5 Analysing the Data

Sharing similar aims and underlying philosophical assumptions, this part of the study also chose to adopt an IPA framework for designing, implementing and analysing the interviews (Smith et al., 2013). All cases were analysed on a case-by-case basis, adopting an iterative and cyclical process of phenomenological and hermeneutic methods (Smith et al., 2013). Ongoing bracketing techniques were used to reduce the impact of any preconceptions emerging from the findings, both here and in the

previous study (Finlay, 2008, 2012). A reflexive diary allowed me to revisit these periodically and ensure the interpretation was grounded in the data and not influenced by previous findings. It enabled new insight and testing out emerging themes with potentially conflicting data (Pietkiewicz & Smith, 2014; Smith et al., 2013). Finally, the procedure for transcription and analysis followed the same steps set out previously (see Figure 5: The Analytical Process of IPA p.109).

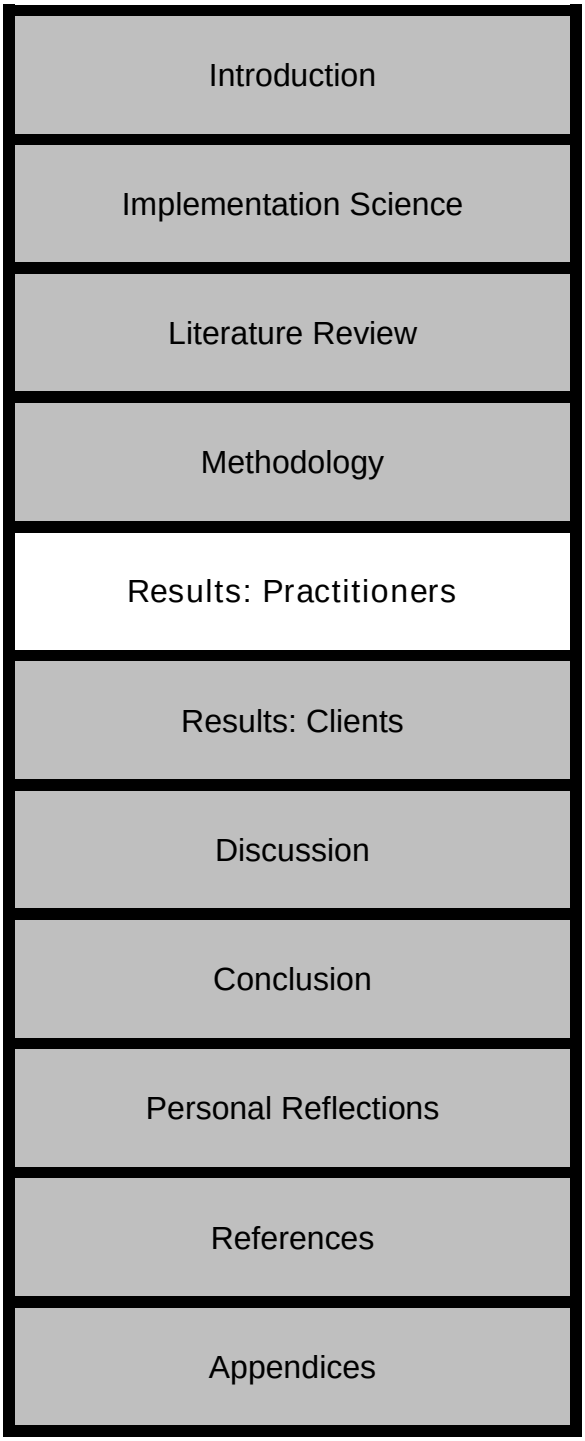
4.8.5.1 Reliability, Validity and Trustworthiness

The same techniques from the previous study involving practitioners to enhance the validity and quality of the research findings were re-applied (Lincoln & Guba, 1985 cited in Lincoln et al., 2011; Savin-Baden & Major, 2013; Yardley, 2000, 2008), particularly the criteria of Savin-Baden and Major (2013, p.476-478). However, different actions were applied at different stages given the variation between groups. The constructs have been reconsidered and restated here to reflect this: methodological coherence (questions included did not require any revision throughout data collection); experience over time (experience in the first part of this research provided confidence in conducting and analysing interview data); triangulation (cross-examination at multiple points, revisiting the data, over and over); audit trail (of particular importance was the technique of ongoing bracketing in respect of the findings, emerging both in the present and first stages); peer examination/external audit (random selection of extracts selected and conferred with another academic); and negative case analysis (actively seeking out data that does not support or contradicts findings and interpretations, encouraging critical thinking and refinement).

4.9 Summary

Understanding the implementation process of the IAPT delivery model requires an in-depth qualitative research methodology. Moreover, a multi-perspective design allows for a more detailed and multi-faceted account of these processes. In analysing these experiences, I have chosen to use IPA, which combines the concepts of phenomenology, hermeneutics and idiography in a rigorous framework that regards the research process as a dynamic activity. It is considered to be best suited to my

research aims that will explore, identify and understand the experiences of those implementing the IAPT delivery model, as well as those engaging with it. Finally, it is considered critical that I maintain the integrity and uniqueness of participant responses, by acting ethically and professionally.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

5 Results: Practitioners Delivering and Implementing Services

5.1 Overview

This chapter outlines the qualitative analysis I carried out using an Interpretative Phenomenological Analysis (IPA) approach for those practitioners delivering and implementing services. The findings are first contextualised using and discussing open-access data that provides a profile of each service. Each theme is then discussed with supporting quotes from participant's data and referenced using the format: "*Quote*" (Name, Line Number of Quote in Transcript). See Appendix 11.8 for transcript key.

5.2 Participant Overview

All participants either chose or were assigned a pseudonym:

"Kevin" is a Cognitive Behavioural Therapy (CBT)-orientated psychotherapist who has been working at the Improving Access to Psychological Therapies (IAPT) service since its inception. His service catchment area covers a largely rural terrain surrounding an urbanised city.

"Gemma and Mary" Gemma is a CBT-orientated psychotherapist and Mary has a background in person-centred counselling. Each played a role in their service's implementation and operation during its initial stages. Their service catchment area covers a largely rural terrain.

"Daniel" has a background in CBT and has been in his role since the IAPT service began. The service's catchment area covers a mainly rural terrain.

"Melissa" has a background in CBT and has been with the service since its inception. She has also worked in other areas of the National Health Service (NHS),

including policy development. The catchment area for this IAPT service covers an urbanised city.

"Isabelle" has a background in CBT, among other psychotherapeutic interventions. She came into the IAPT service around 12 months after its original inception date. Isabelle's catchment area for this service covers an urbanised city.

"Rebecca" has a background in mental health nursing. Her service is self-identified as an IAPT-light service meaning this is not fully IAPT-compliant, although it does adhere to many of the same evaluative procedures. Rebecca's service covers a rural terrain.

"Chris" has a background in person-centred counselling and psychodynamic therapy. Chris' service is also self-identified as an IAPT-light service and covers a rural terrain.

Appendix 11.6 provides further information on these participants.

5.3 Context

5.3.1 Service Profiles and Open-Access Data

See Appendix 11.7 for the Common Mental Health Disorder Profiles and Community Health Profiles of each service, from Public Health England (2015). Table 6 provides a brief summary of key statistics.

Table 6: Brief Area Profiles using Population, Deprivation and Health Indicator Data

	Population (2012)	Health (compared with England average) 2011-14[1]	Socioeconomic deprivation: overall Index of Multiple Deprivation score (2011)[2]
Kevin	221,000	Varied within	16.4
Gemma and Mary	168,000	Generally worse	23.6
Daniel	308,000	Generally better	16.4
Melissa	470,000	Generally worse	43.4
Isabelle	274,000	Varied within	24.2
Rebecca	114,000	Varied within	16.4
Chris	108,000	Varied within	16.4

[1]According to Public Health England Community Health Profile indicators (2015).

[2]Benchmark for England during this period is 21.5. A high number indicates a high level of deprivation. See Department for Communities and Local Government (2011) The English Indices of Deprivation 2010 for more information on how these are calculated.

There can be no direct associations made between population and deprivation statistics in line with service access and recovery rates. Instead, the use of this data is helpful for contextualising participant responses. By using open-access data, it was possible to determine how a service functioned in connection with the national average and one another (see Figure 6 & Table 7). It is important to remember that this is secondary data, hence any limitations in data collection will be inherited. However, responses in the interviews confirmed that on the whole, data completeness was above the 90% target rate across all sites. Lastly, the data from the

IAPT-light services were limited due to their size and small catchment area population.

Regarding area profile (Table 6 & Appendix 11.7), Melissa's service represents the largest number of people. Her service is also within the most deprived area overall, with health considered generally worse compared with the national average. All other areas were fairly similar regarding health, apart from Daniel's area that was considered to be generally better, and Gemma and Mary's area which was generally worse. Melissa's, Gemma and Mary's, and Isabelle's area were above the national benchmark for deprivation, with all other areas similar and below this value.

Melissa's service was the largest with the most referrals received overall and almost five times the number of referrals finishing a course of treatment. Melissa also had the highest access rate with the highest proportion of referrals entering the service and finishing a course of treatment. However, this service also had the poorest recovery rate overall. During the interview, it was discussed that many of the incoming referrals in this service tended to have an initial treatment score in the severe range, making a move to recovery difficult. Looking at the reliable improvement rate confirms this as variation appears to decrease and the rates improve. Gemma and Mary, who demonstrate a similar pattern, also made similar comments.

The service with the highest recovery and reliable recovery rate was Kevin's, however the rate of referrals accessing his service within 28-days was the poorest. Here, Kevin spoke of having a preparation stage before inception that allowed the service to adapt and prepare for it to go live. This kind of preparation stage was greatly desired but not possible among other participants such as for Gemma and Mary, who instead spoke of difficulties in implementing and integrating the delivery model within an already operating service.

Daniel's service had an emphasis on high-intensity treatment, due to his pre-existing and available workforce. Melissa and Gemma and Mary emphasised a low-intensity based approach for coping with the demands of their service, including access rate targets. As demonstrated in her interview, Isabelle revealed that her service was the

most eclectic concerning a choice of treatment, and explicitly stated that her aim was to offer as wide a range of interventions as possible.

The variation in outcomes was most evident for the access rate indicators (40.4% to 61.7%), particularly when considering those who are entering within 28-days (17.4% to 83.5%). The recovery rate indicator also varied (34.3% to 49.1%), although this is not as large as the variation in national figures (24% to 71%) (Health and Social Care Information Centre (HSCIC), 2014a).

Figure 6: Activity of Included Services showing Rates of Referral, Entering Treatment and Recovery

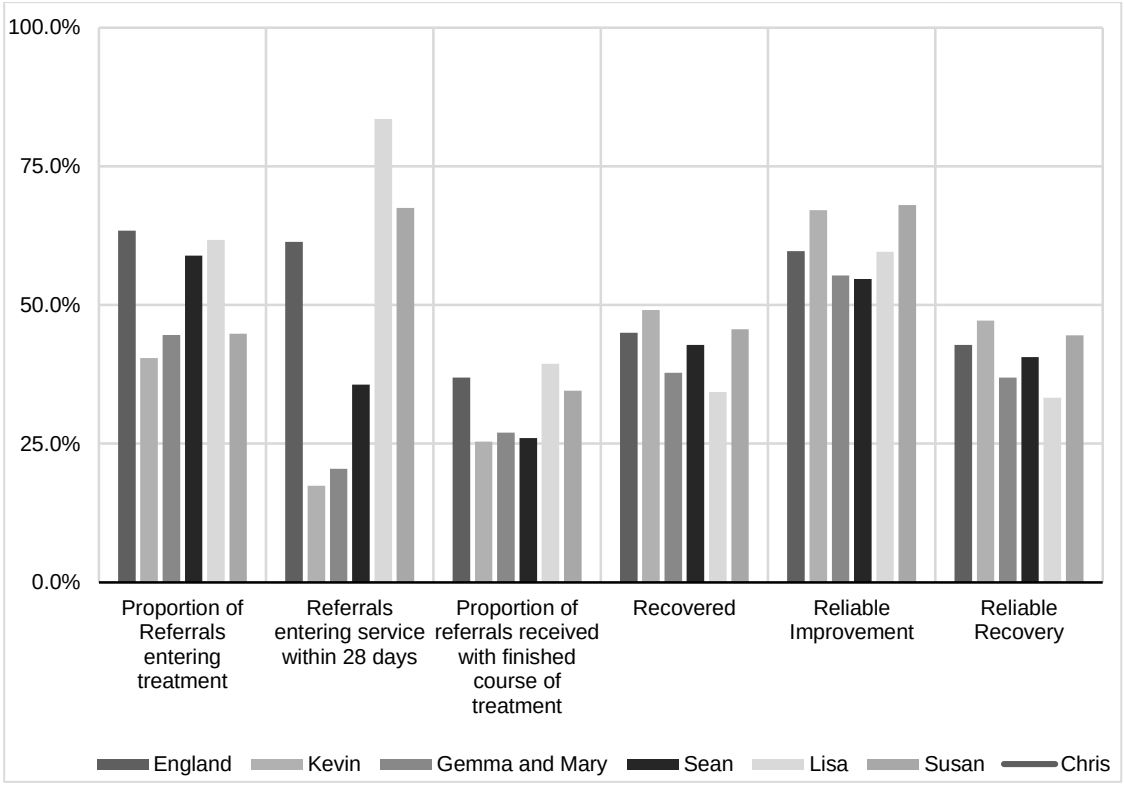


Table 7: Extracted Data on the use of IAPT Services: England – 2013/14 (HSCIC, 2014a)

	Referrals received[1]	Proportion of Referrals entering treatment[2]	Referrals entering service within 28 days	Ended prior to treatment starting having been referred[3]	Proportion of referrals received with finished course of treatment[4]	Recovered[5,6]	Reliable Improvement[7,8]	Reliable Recovery[9,10]
England	1,118,990	63.4% (709,117)	61.4% (435,406)	40.3% (370,627)	39.6% (364,343)	45.0% (143,833)	59.7% (217,591)	42.8% (136,928)
Kevin	5,185	40.4% (2,095)	17.4% (365)	2,285	25.4% (1,315)	49.1% (570)	67.1% (885)	47.2% (545)
Gemma and Mary	3,835	44.6% (1,710)	20.5% (350)	1,830	27.0% (1,035)	37.8% (340)	55.3% (570)	36.9% (335)
Daniel	3,285	58.9% (1,935)	35.7% (690)	1,160	26.0% (855)	42.8% (295)	54.7% (465)	40.6% (280)
Melissa	13,145	61.7% (8,115)	83.5% (6,780)	4,610	39.4% (5,175)	34.3% (1,670)	59.6% (3,080)	33.3% (1,620)
Isabelle	4,845	44.8% (2,170)	67.5% (1,465)	2,570	34.6% (1,675)	45.6% (720)	68.0% (1,140)	44.5% (705)
Rebecca	10	*	*	5	*	*	*	*
Chris	10	50.0% (5)	*	*	*	*	*	*

[1]Referrals with a referral received date within the year.
[2]In order to enter treatment a referral must have a first treatment appointment in the period.
[3]Of total referrals ending in the year (Percentage unknown for local areas).
[4]In order to finish a course of treatment, a referral must have ended in the year with at least two treatment appointments having been attended in the course of the referral. Not a direct reflection of referrals received in the period, as some may be repeated referrals or still in treatment.
[5]Referrals with a completed course of treatment are classed as having recovered if they are classified as clinical cases when they enter treatment but no longer classified as clinical cases when they have completed a course of treatment. Recovery is measured in terms of the anxiety and depression scores. For a referral to be considered recovered, the patient needs to score below the clinical threshold on BOTH scores at the end of treatment, to ensure that recovery is measured by looking at the welfare of the individual rather than one specific symptom.
[6]Denominator based on referrals that finished a course of treatment minus those not at caseness.
[7]Referrals are classed as having reliable improvement if the patient shows a reliable decrease in anxiety or depression score between the first and last measurement, and the other clinical state (depression or anxiety) either also reliably decreases or shows no reliable change.
[8]Denominator based on referrals that finished a course of treatment.
[9]Denominator based on referrals that finished a course of treatment minus those not at caseness.
[10]Reliable recovery counts the number of people where pre- and post-treatment scores exceed the measurement error of the questionnaire and their score moves below the clinical cut-off.

'*' = Where a figure has been suppressed due to small numbers (less than 5, including zero).

5.4 Master Themes and Subordinate Themes

Three master themes emerged from the qualitative analysis, with nine supplementary subordinate themes (Table 8). Although the analysis presents these themes independently, all were felt to be interrelated.

Table 8: Master Themes and Subordinate Themes for all Participants in the Practitioner Sample

Master Themes	Subordinate Themes
A Call to Action	Bringing Order to Disorder
	Constructing Service Effectiveness
Contextual Influences on Service Operation	Embracing Constant Change
	Significance of Agency
	Inheriting the Old Service
	The *Intermediator's* Dilemma
Focus on Relationships	Incoming Clients: Striking a Balance between Individual and Utilitarian Needs
	The Role of the General Practitioner (GP)
	Orchestrating a Cultural Shift and Protecting the Workforce

5.5 A Call to Action

This theme explores the ways in which participants engaged and experienced the implementation process and how they made sense of their use of the IAPT delivery model. It was conveyed as a call to action, with participants describing being part of something great, worthwhile and unprecedented. Generally speaking, the process represented a rare opportunity to bring service operation under control. The task appeared to represent bringing order to disorder, both in the sense of moving beyond a previously chaotic and difficult service provision, as well as introducing some form of structure to the variable and complex nature of mental healthcare. Similarly, participants constructed service effectiveness via various means in an effort to signify their worth and contribution to this effort.

5.5.1 Bringing Order to Disorder

Participants explored their experience of the implementation process by contrasting service provision before and following the IAPT programme's inception. The IAPT delivery model and initiative brought with it structure and concreteness, which contrasted the disorderly and difficult provision that had preceded it. With the newfound recognition and commitment from central government, participants were positive about the programme, expressing feelings of fulfilment, gratitude and pride. These instances are identified in the narratives of Kevin, Melissa and Daniel:

> *"the whole thing is beneficial isn't it, I mean I think... you know it's fantastic at the end of the day just to be part of it, to see this whole movement, and to be treating so many people and getting so many people through treatment, and it's working!"* (Kevin, 539-541)

> *"the investment in IAPT over the last five years has been tremendous"* (Melissa, 315)

> *"IAPT is without question, been a good thing for … um... and helped an awful lot of people"* (Daniel, 453-454)

All three are joined in unison about how incredibly valuable they consider the programme and their place within it. Daniel is stern in his response, removing any doubt about how worthwhile he considers the whole process. The scale by which each participant refers to the programme's impact conveys a feeling of being part of something bigger and greater than themselves. Similarly, it also communicates a feeling of indebtedness and results in a desire to make the most of this rare opportunity. This admiration and sense of awe help to foster feelings of pride and inspiration, representing an emotional charge that keeps them engaged and motivated in their practice and during implementation. Perhaps this is because it finally offers them the chance to move beyond the disordered provision that was a feature of the past.

As previously mentioned, this feeling emerged, in part, due to the experiences of service provision before the implementation of the IAPT programme. Daniel remarks: "*it's an awful lot better*" (Daniel, 447-448) when referring to his waiting list, reflecting on his journey with a sense of relief. Melissa too reflects on this challenging time: "*we inherited a waiting list of about 3,500, and within a few weeks GPs were sending us loads of referrals, that had grown to about 5,000. And we were a much smaller workforce then*" (Melissa, 113-115). Hence, the basis for feelings of gratitude appears to stem from a memory about what provision was like previously. Indeed, the purpose and structure of the delivery model were greatly respected and valued for bringing order to something that had previously been disordered. For Melissa, the scrupulousness and rigour that had been put into the initiative were particularly impressive:

> *"one of the things that's very striking about IAPT is that so much attention to detail has been given to getting all the inputs and the processes right to maximise the numbers of people entering therapy… and having reasonable outcomes, and that's so rare within the NHS"* (Melissa, 438-441)

Melissa's words convey a feeling of astonishment and appreciation about the programme, perhaps suggesting that it is has surpassed her expectations. From her experiences in other parts of the NHS, she can directly compare this effort with other sectors and in so doing, mark out the delivery model's uniqueness. She refers to the

effort as ‘rare’, further emphasising her appreciation that service operation is now made clearer and more straightforward, thus removing instances of doubt and uncertainty. Melissa often talks about this subject in a way that suggests she and her role in mental health are finally recognised as worthwhile, for which she cherishes. The initiative, therefore, offers participants the opportunity to operationalise their approach, in an attempt to derive a greater benefit for the population.

Melissa’s comments resonate with the admiration described by Chris about the programme’s attention to detail and accompanying clarity regarding provision:

> *“Secondary care could learn a lot from IAPT with how it’s structured… it has clarity on supervision, and its protocol is extremely useful”* (Chris, 648-649)

The sheer level of detail described by participants communicate a sense of certainty and assuredness about their actions, pertaining to a kind of security for themselves. Therefore, service provision now seems more distinct and tangible, potentially instilling feelings of purpose and direction, as opposed to a more aimless delivery. It suggests that the IAPT delivery model reduces feelings of anxiety in participants as they are now more self-assured, confident in the fact that their approach is seemingly indisputable.

These experiences characterise the implementation of the IAPT programme as a process of bringing order to disorder. Isabelle and Gemma emphasise the use of treatment boundaries when striving for this order among disorder:

> *“Um… fidelity to the model, it’s about good training, it’s about effective practice, it’s about compliance to [National Institute for Health and Care Excellence] NICE guidance, you know and it ticks all the boxes. It means everybody is sticking to the same model, so we get that standard... kind of, clinical intervention across”* (Isabelle, 332-336)

> “*what we then had to do is adjust their role with what the training was now saying. Which was much more boundaried, much more clearer that you do*

> *this, and you do this in this way… and you say it this way, so it was much more protocolised*" (Gemma, 474-478)

The almost check-list like manner in which these responses are communicated highlights a more systematic approach. For Isabelle, this is described quite literally as ticking all the boxes. Both participants are striving for a distinctiveness between clients, perhaps to ensure the removal of any complication and thus make provision simpler. Tonally and behaviourally, both participants appear calm, settled and self-assured. Again, this suggests that sticking to the treatment boundaries is linked with feeling safe and confident about what is delivered and how the service operates.

Other participants referred to this concept as seeking purity. It was important for both the success and even survival of a service that the delivery model remains focused on treating an: "*IAPT diagnosis*" (Kevin, 31). Consequently, this manifested as various practices that made the demarcation of the IAPT delivery model explicit. Kevin, in particular, was clear on this point, with repetition of the word 'pure' throughout his interview. The following quote from him expands on this concept further, demonstrating how valuable it is for him to keep the delivery model free from interference or confusion:

> *"we basically have our IAPT workers work alongside the [Community Psychiatric Nurses] CPNs, who are traditionally from secondary care services, but actually all working together as one cohesive team. But we keep the IAPT pure… you know, and we don't have CPNs doing any IAPT work or vice versa, but it just means that it's more patient-centred, so you know the team comes around the patient, instead of, of, patients being referred between services"* (Kevin, 19-23)

Kevin justifies his approach as a means to improve client care, replacing a disordered transit between services with something far more concrete and intelligible. It also captures how highly he regards the IAPT component of his overall service, characterising his affinity towards the model as precious and in need of preserving.

This ability to retain the pureness of the IAPT delivery model was not always possible and represented an ongoing task for all participants. Thus, the concept of bringing order to disorder proved challenging in this respect. Specifically, treating those who do not fit the model was recognised as having a direct influence on the effectiveness of the service, leading to tensions in care. Mary's quote exemplifies this:

> *"The more pure the IAPT model is, then the higher the recovery rates, more structure, formalisation, protocol, being strict, improves rates.... But when you're trying to integrate other services, and make considerations for other people who may not fit the model, then recovery rates will come down"* (Mary, 604-607)

Mary considers the idea of purity as linking closely with a mechanistic approach. The idea of being strict and more rigid along the lines of protocol emerges as an idealised reality and one that is constantly out-of-reach. This extract contrasts Gemma's and Isabelle's earlier point about the need to stick to treatment boundaries. Although she recognises what it would take to improve the effectiveness of her service, there is an internal dilemma about excluding individuals from treatment. Instead, they incorporate a broader approach to their inclusion criteria, recognising the limitations for a stricter course of delivery. Rebecca also refers to this, expressing the challenging demands on her during this process:

> *"it's really difficult to put boundaries down"* (Rebecca, 86)

Being solely responsible for a particular area, with no clear links beyond the service was linked with having to incorporate those who do not fit the IAPT delivery model (see also Significance of Agency p.147). It represented a heavy burden for several participants, including Melissa, Gemma and Mary, and Rebecca, as their options to treat these clients were ill-suited, yet they felt the need to offer some form of support:

> *"one of the things that, the other … services, can rely on is, is… a continuous pathway you know, into step-4 and step-5 if necessary, and they're always*

> *tension points for us. It isn't that easy, I mean work on it, but it isn't straight forward"* (Melissa, 374-377)

Melissa opts to treat these clients in spite of the recognition that recovery rates will inevitably come down in treating them, seemingly inviting undue pressure on the participants. Notably, this contextualises some of the situations described by practitioners who found it difficult to bring order to disorder; disorder being those who do not fit the IAPT delivery model or way of working.

Another notable obstruction to bringing order to disorder was the influence of other health professionals beyond the boundaries of the service. The referral practices of these practitioners were particularly problematic for participants, as those who do not fit the model were more likely to access the service. Melissa explores these phenomena further, contemplating the perceived role of the IAPT programme among other health professionals:

> *"like many other mental health trusts, access to talking therapies is in short supply, so I think psychiatrists tend to refer to us and... very often, the referrals at the moment are not necessarily appropriate. But they're just trying to access some form of talking therapy for their patients and, you know invariably, they might, they might be for the management for voices by people with psychotic conditions and that's not really our bag"* (Melissa, 63-68)

Melissa's experiences indicate that the role of IAPT services had become synonymous with psychological therapies in general and a sort of repository for all things regarding mental health. Although sympathetic to the plight of other sectors, there is a notable strain in her having to accommodate for inappropriate referrals that stood to threaten the purity, purpose and potential of the service. The metaphor of 'our bag' suggests that while she is willing to take on this responsibility, it nonetheless creates uncomfortable and difficult feelings about who to include and exclude. Their purpose as an IAPT service is to support only one component of the client's mental wellbeing, yet others were misunderstanding this. Therefore, it appeared that participants were expected to work beyond their remit. This links in with other concepts about seeking integration (see Embracing Constant Change

p.143) and engaging with other health professionals (see The Role of the GP p.164). Consequently, this means it is useful that the complexity of a client is identified early on and thus excluded (see Incoming Clients: Striking a Balance between Individual and Utilitarian Needs p.159). Similarly, it also suggests that the growing inclusion of self-referral practices (see The Role of the GP p.164) affords services the ability to determine who is suitable for the service, instead of relying on other health professionals. Accordingly, this further supports the participants' needs to enhance order among disorder, by removing the complexity or inappropriate clients. It may also be due to their dislike of service provision before the IAPT programme, which means they are more willing to implement greater control at this stage.

Although being mindful of the need to include a stricter approach to delivering treatment, participants recognised this would likely lead to gaps in care and between services. For Isabelle in particular, the process of implementation was an activity in addressing these gaps:

> *"I: So they're not on [Care Programme Approach] CPA, they're deemed to be secondary care but there not actually on CPA, but they're not primary care, so it's the people that fall in between… so we've now got a service available for those clients basically, you know because obviously, you do get people in secondary care services who suffer with anxiety and depression… but, but they're not quite, they don't quite hit the mark for secondary care services for psychological therapy interventions, and previously they weren't quite eligible for our services either, so we're trying to bridge that gap.*
>
> *R: Oh right. Do you hear about a lot of people who fall through the gaps, in the middle?*
>
> *I: Yeah absolutely"* (Isabelle, 51-62)

Isabelle is required to be particularly pro-active when it comes to addressing gaps in services, appearing to go above and beyond duty. She is also without any doubt when it comes to accepting that clients are falling through these gaps. The consequence of striving for a stricter approach seems to have resulted in an opportunity for clients to

fall in-between sectors, resulting in an indeterminate stage of not being entitled to care in either one. Relating this to the wider narrative, it appears that Isabelle perceives the application of a rigid and structured approach as benefiting the provider, however for the client, this presents a problem. Consequently, this further highlights the challenge of the concept in bringing order to disorder throughout implementation.

5.5.2 Constructing Service Effectiveness

The feelings of pride, gratitude and fulfilment all contributed to a participants' desire to prove themselves by ensuring their service is recognised as an effective and valid IAPT or IAPT-light service. Constructing how service effectiveness is understood represented a source of dispute among participants. Principally, this involved debating whether current empirical practices were a true reflection of service effectiveness or other sources were more important. Firstly, participants considered the collection of data as integral to their practice, even instilling feelings of pride in Melissa:

> "*I can cheerfully claim that for about 96% of all sessions you get outcome measures, and outcome measures are seen as an integral part of therapy… so we, and our information team will check, but it is something we do as a matter of course*" (Melissa, 202-205)

The level of joy referred to here is born out of an ability to lay claim to achieving high levels of data collection. Its central position and systems of checking indicate how crucial this activity is to the perceived success of the service. In other instances, throughout Melissa's interview, as well as from all other participants (excluding Chris), this practice provides a tool for more immediate self-analysis and feedback. Thus, it appears that the emphasis on data collection in these services is useful for the implementation process, as the impact of new approaches can be more readily assessed. Notably, Gemma finds solace in her actions about modifying the delivery model, highlighting that their effectiveness as a service remained intact:

> "*And we've also found that just by changing the process that the [Psychological Wellbeing Practitioners] PWPs do the majority of the assessments. Actually, what we thought is we'd get more people stepped-up. It's not the case. Actually, our recovery rates haven't changed… and they are treating more people and stepping up far less people*" (Gemma, 323-327)

Gemma's extract supports the idea that treatment scores are pivotal in constructing service effectiveness among participants. Their use means that they are more willing to adapt their service to suit the pressures on them for increasing access and recovery rates.

Another advantage of using Routine Outcome Monitoring (ROM) was highlighted by several participants (Kevin, Gemma and Daniel) who described using treatment scores as a means of validation and confirmation to communicate to the client that they were improving. The following quote from Kevin demonstrates this:

> "*it's therapeutic sometimes to be able to, for the client, to say it's terrible I can't see there's no improvement, and it's been a hard week, and whatever… and then review the scores and say, well actually, do you know that that's actually you know, you can see, that's whatever… that's 6 points better than it was, or sort of use that as evidence and to help to sometimes challenge things*" (Kevin, 305-309)

In this account, Kevin appears to be reliving the interaction he has had with numerous clients. He describes the use of the scores as being 'therapeutic', conceptualising them as being almost like another kind of therapist in the room. The scores are therefore useful as proof for when a client's insight is restricted, or they remain unconvinced. A change in scores helps to argue his case, conceiving it as building confidence in him as a therapist from the perspective of the client. Similarly, both Gemma and Daniel emphasise the importance of sharing this information: "*we're also very good at sharing that information, that it's not just us for our recovery rates, you know, it's also about that person's process*" (Gemma, 298-299); "*we take a positive attitude to information sharing, we're not precious about the clinical notes, the clinical notes are there to help inform, in acting in the*

patients' best interest" (Daniel, 215-217), thus further supporting their usefulness as a tool to keep clients engaged.

The importance of data collection can be identified in the following quote from Mary:

> "*Slightly different from the counsellors because, it's… it's something that traditionally they feel interferes with the counselling session, so we've had to, we've had to sort of persuade them that... well in actual fact we've got to do it. Because if we're going to be an IAPT service they were, they have to do it*" (Mary, 279-283)

It appears that to identify being part of an IAPT service practitioners are required to engage heavily in the collection of data. This condition is emphasised in spite of resistance from therapists practicing in different therapeutic modalities who may feel uncomfortable with ROM. Mary seems to be uncompromising towards those concerned, stating that their identity as an IAPT service would be at risk. Here it does not seem that data collection is considered useful for improving the service but is instead conveyed as being a kind of necessary evil.

Although data collection was considered crucial by all, paradoxically their usefulness and appropriateness for judging the overall effectiveness of a service were considered problematic. Melissa communicates this issue:

> "*R: Do you know roughly at the moment what your recovery rates are?*
>
> *I: About 34%. Okay. So, um, I don't know whether you've looked into recovery rates, but they are, essentially a technical definition and if you look at the audit of first wave IAPT sites by Gyani et al., you will see that recovery rates are very much contingent on kind of entry scores… of outcome measures. We tend to see people at the more severe complex end, and with, you know, I've got a comparison of IAPT entry scores for [Patient Health Questionnaie-9] PHQ-9 and [Generalised Anxiety Disorder 7- Item Scale]*

> *GAD-7 compared with a national profile and it's very clear that we're bunched up at that end*" (Melissa, 267-274)

Melissa's account implies that she and her service are in a disadvantaged position. Depreciating the usefulness of the recovery rate measure, she refers to it as being just a 'technical definition', therefore appearing quite dismissive of its suitability. It appears that this current approach is considered limited and somewhat unfair, perhaps suggesting that some have done a similar comparison between her service and others.

The contingency of entry scores chimes well with Kevin's experiences, who speaks of resisting a dishonest incentive:

> "*We certainly don't in this service, cream off those mild-to-moderate clients that are already close to 9 or 7, and that's easy to get to recovery... and we see a lot of services doing that*" (Kevin, 434-436)

This suggests that Kevin has direct experience of witnessing other services that favour the treatment of certain clients for boosting their recovery rate. Although noble in his approach, there appears to be an underlying sense of resentment for services that practice in this way. While the limitation of the recovery rate measure is readily acknowledged, they still impact on both his and Melissa's experiences, as they try to uphold a level of integrity. Therefore, this represents a tension point in constructing their own judgment about service effectiveness. Kevin later speaks of his appreciation for Payment by Results (PbR), which he considers will remove the: "*perverse incentive*" (Kevin, 450), similar to Gemma's comments: "*we think our [Key Performance Indicator] KPI recovery rates will shoot up then*" (Gemma, 508). Accordingly, this characterises the objective use of scores without reference to context as being clumsy and inadequate, demonstrated by the participants' resistance.

All participants emphasised the value of seeking other sources in constructing service effectiveness, perhaps to overcome the limitation of using solely empirical techniques. Therefore, judging service effectiveness appeared to emerge as an internal construct and not just an objective application of the model. It was

considered that treatment scores did not necessarily match to what was effective or perceived to be effective in the therapeutic session with clients, as exemplified here by Daniel:

> "*it's interesting how patients' perceptions about what they found helpful, or how well they're treated or how useful they find a certain course, doesn't necessarily map exactly onto clinical outcomes as measured by, your measures*" (Daniel, 417-419)

Despite the scores being useful in challenging clients who perceive they are not making progress (see above), these scores may not adequately represent their perception of what is working in treatment. Hence, client narrative was considered to be a valuable source for constructing perceived effectiveness. All participants tended to favour client narrative above all else, with the following quote from Isabelle highlighting the general characteristics of this pattern:

> *"You know… doesn't get measured as recovery through the KPIs, the national targets but, you know, if a patient says to me, I feel so much better, I've actually got the confidence to go out and get myself a job or I have gone and done this, then I think that's got to be taken as you've done something well"* (Isabelle, 385-388)

As suggested in the quote above, Isabelle believes that what a client says about their recovery is paramount and should be recognised above all else. In her response and tone, it seems that the methods for recognising this aspect of recovery are not always acknowledged. Therefore, this appears to undermine the efforts of participants in their service delivery, possibly leading to tension points. It is possible that Isabelle is longing for an opportunity to communicate this aspect of service effectiveness. Indeed, she makes mention of the patient opinion website elsewhere in her interview, priding herself on the positivity of narratives uploaded there.

A final source of constructing service effectiveness was determining whether outcomes were sustained or not. For Daniel, this required the use of a follow-up procedure:

> *"how can you be sure that somebody is going to sustain, what's important to the patient is that they stay in improvement without the regular therapy… so it's not just about getting people through, a sausage machine off the other end of the line"* (Daniel, 341-343)

Daniel's quote stands in contrast to the experiences and rationalisation of Melissa, who was unable to implement a follow-up procedure due to the size and demands on her service. Nevertheless, she justifies her approach by stating: "*we do put emphasis on relapse prevention in therapy*" (Melissa, 289), while also repeating the availability and use of a self-referral pathway. Both participants seek proof about their service's effectiveness in different ways. It appears that Melissa is restricted in the context of her service but finds consolation in implementing a more open-door policy for clients to access beyond treatment cessation. For Daniel, constructing service effectiveness means resisting what he considers being misleading and short sighted gains. He conceptualises this approach and the temptation to emphasise a greater throughput as dehumanising, mechanical and unfeeling. Thus, in constructing service effectiveness, participants appear to use many different components, rationalising their approach in light of the clinical realities of their service.

5.6 Contextual Influences on Service Operation

This theme considers the wider contextual influences on the delivery and implementation of services as participants attempted to make sense of the pressures on them as an individual. This process represented a highly iterative activity, characterised by a process of trial-and-error. Moreover, each participant explored the expectations of them and their role in making the service as locally relevant as possible, while still remaining faithful to the IAPT delivery model and its overall purpose.

5.6.1 Embracing Constant Change

As explored in a previous subtheme (see Bringing Order to Disorder p.131) it is important that aspects of the IAPT delivery model and its underlying philosophy

remain intact. Beyond this, participants were tasked with developing a locally relevant service that was characterised as being both reactive and adaptive. Daniel elaborates on this, representing implementation as a process of refinement:

> *"I think it would be fair to say that we're pretty much still centred on the original IAPT specification in terms of trying to greatly improve our access for the large number of people with more common mental health problems, and to improve and refine our, that, in … as a resource which they can access easily and quickly and find beneficial. So, um... we haven't actually gone heading off in different directions, other than kind of refining that, and trying to operationally improve our systems to make it work as well as possible, for as many people as possible, in the context of the way that, that's kind of by local geography and service configurations outside of our services and so on, and referral patterns and issues"* (Daniel, 376-383)

Here Daniel justifies his approach by constantly referring to the central purpose of the IAPT programme: this being to derive the greatest possible benefit for the largest number of people possible. Being a responsive service means adapting the peripheral aspects so as to not lose sight of this purpose. At the same time, the service context appears to be hugely influential and possibly even a burden, as indicated both here and elsewhere in Daniel's interview. The complicated nature by which this process occurs communicates change as inevitable and constant. In his current role, he must embrace this change or fail to be locally relevant. Considering all participant responses, this is not necessarily a clear-cut process with it instead involving a series of iterative steps. This is perhaps due to the numerous, interacting and mediating factors that act to create uncertainty in a participants' approach. Melissa refers to this when describing her ambition to become a more integrated and connected service:

> *"I think what really matters for the success of any IAPT service is the extent to which it's actually integrated and connected with a whole range of other services, which you know we're certainly... we've tried very much to do in …, and your job is never done there, it's like knitting a jumper"* (Melissa, 398-401)

Melissa's use of the metaphor 'knitting a jumper' refers to the number of threads and factors continually interacting, demonstrating the intricate nature of implementation and how she experiences it. Again the process of adaptation is conveyed as being never-ending and is therefore, hard to pinpoint. Her use of imagery in knitting a jumper is strange as a jumper can indeed finish being knitted. It perhaps communicates that she is hopeful one day her job will be done, however at present this seems out-of-reach. The idea of implementation being a process of integration is similarly echoed by Kevin, Daniel and Gemma and Mary. Such was the extent of this that Kevin identified himself with a new label:

> "*I keep hearing providers calling other providers, referring to us as the IAPT-plus model where we can take all comers and deal with… and IAPT is part of a single point of access, integrated service. It's that integration that's been the big thing*" (Kevin, 466-469)

This outlines integration as being a defining goal in the implementation process for Kevin, shown by his repetition of the word and reintroduction of this concept throughout his interview. Embracing constant change has helped create something more than IAPT for which he is proud. His relaxed demeanour contrasts an uncertain and possibly stressful time preceding this stage, with several conflicting pressures having been put on him and his service (see The Intermediator's Dilemma p.154). Now that integration is functioning as well as it ever has, according to his narrative, service operation appears to be more harmonious, thus portraying a sense of relief.

Exploring the concept of constant change and its place within the implementation process, Isabelle emphasises the actual rate of this change:

> *"Um… IAPT was, you know, a pretty new initiative really wasn't it? So you know we've been around for four years now and we're in wave 6 of recruitment, so we've got a massive workforce at the moment…we've got, God, around 75 trained IAPT workers, so we're a massive service, so what have we changed? I mean everything's changed"* (Isabelle, 462-466)

Isabelle makes repeated use of the word "*everything*" in other parts of her response (462 (x3), 466, 479), identifying the huge transformative experience she has had during this process. By emphasising the IAPT programme as new, this implies that in its early stages she had felt particularly ill-equipped to meet the demands of the local population and context. Therefore, embracing constant change is characterised by an almost aimless progression, uncertain of what the outcome will be and how best to get there. Isabelle appears surprised and somewhat overwhelmed when contemplating the sheer level of change since its early inception, also impacted by the fact that she is responsible for a large service. For Gemma and Mary, when asked about the topic of service transformation and change, their experiences were similar:

> *"Constant. Constantly, if you came back in 3 months' time we'd probably be telling you all sorts of different things"* (Mary, 433-434)

Mary's account again characterises implementation and service delivery as an ever-changing enterprise, possibly interfering with participants' familiarity with the current delivery model. In her response, Mary seems accepting of change, similar to Melissa, but it also suggests some ambivalence towards the actual rate of change demanded of her, usually from changes in top-down pressures. Therefore, constant change and the need to embrace this change seems to be born out of the evolving pressures within the IAPT programme, and not just demands of the local area context.

Kevin and Gemma and Mary described some innovative and creative practices that had emerged as a result of these evolving pressures. The IAPT delivery model and stepped-care approach were particularly useful for allowing participants to embrace change, allowing for a more flexible structuring of the workforce. Consequently, these various factors compelled them to organise their service akin to that of a 'call centre':

> *"the PWPs they stay in our sites, in our wellbeing centres and that's because the majority of the stuff they do is telephones, so there's a big plan office upstairs which can seem a bit like a call centre at times"* (Kevin, 315-318)

> *"because it didn't start out that way but we've gravitated towards that, even though I know some services start out with that… PWPs are put in like a call centre, we always said we wouldn't do that. But actually the telephone work they do is actually the most productive work, they love it! And they actually, now that they're into it, they enjoy doing it"* (Gemma, 259-263)

At first, it seemed difficult for both these participants to confess to providing a service that more closely reflected a 'call centre'. However, it made sense for them approaching treatment delivery in this way. One prominent influence was responding to the changing and ever-increasing demands on their service, which at the time was heavily influenced by a 15% access rate target (this being mentioned by several participants including Isabelle, Kevin and Gemma and Mary). By committing to engage in practices that went against their own biases and prior assumptions, Gemma and Mary reveal that certain approaches were not only a necessity but a rewarding and surprising activity too. Therefore, embracing constant change was an essential component for managing these evolving pressures.

5.6.2 Significance of Agency

Much of a participants' work was driven by the need to improve access, which became increasingly difficult in light of geographical constraints, which tended to make service delivery difficult. It was believed that this could greatly impact on client agency, both in the sense of their mobility, as well as their willingness to engage. In the next extract, Daniel contemplates on the impact of geography within his area:

> *"Yes it's very much a driver in ... You can't improve access, or prove anything like an IAPT service which does what it says on the tin unless you actually provide outreach access"* (Daniel, 127-128)

Daniel identifies clearly the primary driver behind his actions, in simplifying the primary aim of the IAPT programme. His resolute demeanour conveys an unyielding determination for overcoming this obstacle, as failing to overcome this would indicate his role within the service is false and deceptive. Elsewhere in his narrative,

he describes the task of overcoming geographical constraints as complex and uncertain, while here the solution is presented as fairly straightforward. Accordingly, this contradiction may result in feelings of guilt and stress, as although the solution and expectations on him are straightforward, the means and practicalities about how these are achieved are not. Melissa explores this concept further:

> *"we will, try and make ourselves as accessible as possible, that's not to say that there isn't more that we can and should do, in terms of reaching out to particular groups, I think there's always an issue for IAPT services, and it's you know... a particular issue for services like ours"* (Melissa, 182-184)

For Melissa, the task of making the service more accessible is also highly influential. However, she seems modest about her current efforts, even feeling troubled that certain groups are not being reached. Extending this to all IAPT services, Melissa is able to find some solace that client agency and accessibility is an issue everywhere and in particular for a service like hers. This indicates that client agency and engagement is an ongoing struggle.

In a similar way to Daniel, Mary also rationalises her actions by restating the core purpose of the IAPT programme regarding access:

> *"often getting to the central point is difficult, and particularly when the central point which we are, is not in the central point of … so anybody catching a bus from somewhere actually 10 miles down the road, has to actually go into town centre to come back out… whereas if we can be in their area, then maybe they've only got to get a bus a couple of stops down the road if they can walk there, sort of thing. So that's the main aim, isn't it? To provide it as locally as possible*" (Mary, 239-244)

Mary imagines the journey from the perspective of the client, identifying this as a compelling issue and in need of addressing. There appears to be an underlying sense of guilt and responsibility in her about their current situation and the problems it causes within their area. The contrast in examples seems stark, with the latter being

far more appealing to a potential client. However, this rests on a conjunction in which providing local access is not always possible, likely generating tension points.

Location and geography were less of a concern for Isabelle than others, mainly due to the transport links she had at her disposal:

> *"This is great, bus station's there, trains there, and there's parking over there if people want to come in the car, so it makes it very accessible. Location yeah... absolutely is key"* (Isabelle, 237-238)

In this extract, it is clear that she is grateful for the location she has, mainly because it can cater to various types of transport for clients to use. It appears to be a cornerstone of the success of her service as she declares just how critical her location is. This gives Isabelle a positive outlook for her potential clients accessing the service, as she believes a sense of burden has been removed. As highlighted elsewhere, this is not necessarily the case for other participants.

According to Chris, the issue of geography could also impact on the agency of his workforce, again making provision difficult:

> *"the availability of supervision is problematic and then the capacity of individuals to deliver it is also problematic. And because where we are, geographically, it's very difficult to access somebody that might be a supervisor in ... because it takes an hour and twenty minutes, so that becomes an issue"* (Chris, 418-421)

The time taken to travel represents a strain and unease in Chris about the inefficiency of arranging his workforce to supervise one another. The task becomes even more difficult when attempting to arrange supervision for practitioners higher in the chain of command or with greater experience or expertise. This demonstrates the intricate and delicate nature of the organisational dynamics; particularly how sensitive it is with regard to the impact of geography or agency.

5.6.3 Inheriting the Old Service

All participants described the influence of the service that had preceded the IAPT programme's implementation, particularly regarding long-standing issues, such as waiting lists. Likewise, the point at which the IAPT service was incepted appeared to create a great deal of angst, as it was felt to be heavily rushed and ignorant of acknowledging the pre-existing service. Daniel explores this concept further:

> *"I: Well we started in the red, with an 18-month waiting list, whopping great waiting list.*
>
> *R: And that's down to 4-6 weeks now?*
>
> *I: Yeah. Well for treatment? No, it's still a few months for some people to start treatment, but yeah it's an awful lot better. But again the IAPT model performance monitoring assumed zero waiting list, you know, scenario, so it's very much one of those questions... you know, if going back 4 or 5 years we were going to start an IAPT service from scratch, you wouldn't have started from there*" (Daniel 443-450)

Daniel describes the waiting list itself as enormous and something that he still cannot quite comprehend. In saying this, he begins to trail off as if to reflect on the long journey that he has endured up to the present day. Later referring to it as an 'awful lot better' you can sense the relief in his voice having gained some control. Nevertheless, he is still sensitive to the fact that the expectations of him and his service were unrealistic and ill-informed of the fact that the waiting list and pre-existing context was so impactful. Therefore, he appears to have felt greatly disadvantaged and misunderstood regarding the demands asked of him. This also resonates with Melissa's experience, who speaks of having to prioritise and sacrifice certain elements of her service to meet the urgency and pressures placed upon it:

> *"we inherited a waiting list of about three and a half thousand, and within a few weeks GPs were sending us loads of referrals, that had grown to about 5,000. And we were a much smaller workforce then, we were about 35, and*

> *what should have been a screening procedure grew into, well let's try and offer something… so let's do, you know, a decent assessment and offer some self-help and sign-post people to other places if we can"* (Melissa, 113-120)

Again the former waiting list is referred to and even increases at the point of inception, leaving Melissa to feel overwhelmed. As a result, she is forced to re-structure her service so that incoming clients can at least have 'something'. This tokenistic response emerges as a result of the pressures being put on Melissa and her service, perhaps stimulated by a lack of awareness regarding the impact of the existing context. Melissa later describes in her interview that this aspect of provision has since been revisited in light of the now more manageable waiting list, five years on. It is notable that Melissa refers to this moment in time, with her experience and feelings reflecting that of remorse, as more could not have been done. Her pragmatic response also demonstrates how during implementation the purpose of one procedure had evolved into another; in this case, screening becoming a platform for therapeutic delivery.

Both Melissa and Daniel explore the idea of unrealistic expectations further, notably concerning the lack of consideration of context by others during implementation:

> "*it's like somehow you're in some petri dish, with a bunch of other IAPT service leads and, clinicians and staff were grown that didn't know anything else, and that's just what they started doing*" (Daniel, 498-499)

> "*I think there were expectations that you take a service off a shelf and it would be up and running when actually it's been a developmental project*" (Melissa, 361-362)

The context in which Melissa and Daniel are implementing their IAPT service presents a predicament. It seems that requests and expectations placed upon them are unaware of the fact that there already exists a workforce with expertise in this area. It is interesting to note that Melissa uses imagery of taking something 'off a shelf', perhaps representing a consumerist and reductionist ideology. Compare this with Daniel's comment of being in a kind of 'petri dish' and it further highlights a kind of

artificiality. Moreover, it highlights the fact that certain components had not been considered adequately enough, namely the service and community context. The difficulty lies in incorporating the advice and skills of others already working in this area. Therefore, it seems naïve to expect that a new delivery model could be fully functional and achieve good results so rapidly, particularly given the iterative nature and uncertainty characterising the implementation process.

These experiences may be due to the early stages of implementation being particularly rushed and chaotic, as exemplified by Mary:

> *"I think we weren't, we didn't have a huge amount of clinical leadership at the time, and we just kind of did our best, with a lot of trainees, a lot of inexperienced staff, and quite overwhelmed existing staff trying to hold everything together. So I think, well I found it quite an extremely stressful time with, at times quite anxious staff, who really were not sure, who, you know, quite a lot of generalised anxiety within the team"* (Mary, 558-563)

This notion of doing one's best is similar to Melissa's account. Implementing and inheriting the old service was very much about navigating the uncharted, while also managing the burden of an already functioning service. Mary speaks of an anxiety being shared among her colleagues as she attempts to contain and subdue its impact. The uncertainty, confusion and feelings of being overwhelmed also link to comments made by Gemma about her workforce feeling stretched (see below). Although supposedly on the mend, it is clear that this experience has left both Gemma and Mary feeling exhausted and overworked. Given the complexity, uncertainty and the multitude of factors involved during this process of integration, it is notable that Melissa and Gemma and Mary all longed for a more suitable preparation stage:

> "*Yes, yes and I think I actually... yeah I don't, I would have said look, hang on… let's think very carefully about how we're going to grow this in a way that links us to patients using the service and the practitioners that work at it*" (Melissa, 366-368)

"G: we couldn't say, oh we're going to do this, we're going to shut our doors for 3 months and we're not going to see anybody, just you know… ignore our waiting list and, that's the other thing you tend to take on an IAPT service with a current waiting list and caseload, and that's quite difficult. But, because your existing staff are stretched further, because they also have to then support and train the new trainees, so yeah it was tough, yeah we got there.

R: So you're on the other side now?

M: Yes, absolutely, until they change it again! (laughs)" (Gemma and Mary, 589-596)

Melissa is figuratively putting some distance between her and others so that she is able to carefully plan and reflect on how the model would function. Her speech is much slower, potentially reflecting a deeper contemplation of the issues she is discussing. Instead, the urgency and expectation placed upon her and her service likely mean that implementation felt somewhat haphazard, given that suitable preparation was initially absent. Gemma recognises that preparation isn't necessarily possible due to the ongoing demands of the existing service, although she agrees that managing existing staff and a pre-existing waiting list was extremely challenging. For Gemma and Mary, the change in demand on services are constant, which may also be true for others given the rate of change referred to elsewhere (see Embracing Constant Change p.143). Humour may be used to mask the underlying strain felt by both of them, as they may feel overwhelmed by the rate of change and need to adapt. It also suggests that the nature of change is erratic and at times either unmanageable or not feasible. Being ignorant about the extent of these challenges placed upon participants during these stages appears to have resulted in undue stress and possibly led to their practice feeling impeded.

Extending beyond the boundaries of the service, participants had to deal with how others perceived them during the early stages. This refers to how accepting other professionals were of them and their service being implemented. Therefore, inheriting the old service meant considering the impact this had on other sectors

losing that service. For Kevin, the implementation of this new specialist model was met with a general dislike and suspicion:

> *"I think I would have moved it towards, you know, the integration sooner, to stop IAPT from just being, we were a bit unpopular in the early days, of being another specialist service, you know, who's just purely CBT, just a specialist CBT service in primary care. I would have moved it earlier towards that integration with all the other mental health services"* (Kevin, 560-563)

It is clear in Kevin's response that the unpopularity felt during these stages were difficult. With the gift of hindsight, he talks about how integration with other services is the ideal and that working in silos was challenging. It indicates that during the early stages his service was ostracised by others leading to him feel isolated and out-of-touch. This also ties in with his view that implementation is about integration and that his IAPT service has since become something more i.e. 'IAPT-plus' (see Embracing Constant Change p.143). Therefore, implementing an IAPT service requires being flexible to integrate the service with others, responding to their ways of working and allowing enough resource for inheriting the old service.

5.6.4 The **Intermediator's** Dilemma

A notable pattern which emerged in participants' experiences and characterised the implementation and operation of services were acting as an intermediary agent. This involved accounting for multiple, and at times, conflicting demands being placed on services. Because of this, participants generally described the process of implementation as a watchful balancing act, seeking an ideal with the reality in mind. The separation in roles is demonstrated in the following quote from Mary:

> *"there's quite a large amount of people in the middle of that… a fair proportion of people who are actually beyond, traditionally what an IAPT team should work with. However, we have pressures from the mental health side of the trust to work with some of these people, and although we obviously have pressures as well with our KPIs, to keep within an IAPT*

> *model. So we are constantly, looking at this hiatus, whatever you want to call it, between the two"* (Mary, 490-495)

Because of the current situation within her service, there are demands on Mary to try and cater for people who may be considered too severe for an IAPT intervention. These pressures conflict with the primary task of the IAPT programme in treating mild-to-moderate Common Mental Health Problems (CMHPs) (see Bringing Order to Disorder p.131). As the process is not always certain this requires constant monitoring. Consequently, this appears to leave Mary and possibly her workforce, feeling uncertain about which goals to prioritise.

One other pressure on participants at the time of the interview was the requirement to reach a 15% access rate target. This was considered to be a particularly challenging task as the resource required to reach it was lacking. Gemma describes the difficulty of this:

> *we're trying to address where our gap is and where we think we can make up to the 15% quite realistically, without extra capacity, because you know, for us it feels like we're working at capacity, and to get to 15% actually feels like quite a jump. So we have to do things differently, I think is the reality of it, so we're looking at where we think we can make most change* (Gemma, 440-445)

Unfortunately for Gemma, she feels as though she is stretched as far as she can go. She likens the effort to do so as 'quite a jump'. Considering the resources she has available and the multiple pressures on her, she is forced to restructure the service, despite being uncertain about how to do it. Her ability to reach this ideal in the context of her reality therefore seems illusory and out-of-reach, leaving her with a dilemma. Conversely, she may also be optimistic about the challenge and relish the opportunity to innovate, something which characterised much of her narrative when discussing the implementation process.

The concept of a reality not matching with the ideal also concerns the issue of accommodation. For Melissa, Daniel and Chris, this was a particular challenge and

appeared to leave them feeling inhibited. In the following extract, Melissa refers to the issue of accommodation, or rather lack of, resulting in her service feeling as though it is at tipping point:

> *"at the moment accommodation is an issue for us so we don't have, don't necessarily have room space to conduct supervision more frequently but... and despite the intentions of services, that's what we've got. And so, in … for example you find it's better placed. But this is an administrative base, you know we're bursting out of the seams as it happens"* (Melissa, 244-247)

The strain of not being able to provide adequate accommodation deeply troubles Melissa. Her use of metaphor and word choice 'bursting at the seams' highlights a pressure that is particularly burdensome. She resigns herself to accepting that this is what she has to deal with and therefore, struggles to move beyond the constraints of her service. It also highlights the pressure on participants and their service beyond the task of solely delivering therapy.

There are other hard to define factors involved in the operation of services that each participant must contend with. Kevin refers to the wider context of the NHS as having an intrusive impact on his ability to implement and deliver therapy:

> *"I think the main thing that's wasteful right now is the Any Qualified Provider competition tendering, that I'm spending so much of my time, I've been pulled out of this service to support the trust with the clinical aspects of their tenders in our IAPT, across our IAPT services. So much time and resources are being pumped into this which is wasteful because if, in two years' time nothing terrible has happened, we're still delivering treatment in the service the way that we are, hitting all of our KPIs, delivering a tiny service, doing everything the GPs want, they're satisfied, everything is working really well, but they have to re-tender the service… no matter what"* (Kevin, 542-548)

This demonstrates a struggle for Kevin as he is pulled away from his service, as he sees it, unnecessarily. Using a hypothetical, but likely situation in the future, he

recognises that the demands placed on him from one source do not naturally align with the priorities of the other; this being to concentrate on delivering treatment. This is described as a clear inefficiency in service operation as the achievements of the service matter little in light of these pressures. It is probable that Kevin is highlighting a lack of communication and understanding between the forces acting on him, culminating in his frustration. Other pressures on NHS services include an administrative workload, which is contemplated by Daniel:

> *"I think it would be fair to say that in our service we do try and minimise the rest of the bureaucracy side of things. Bureaucracy has been a huge play upon public services, in particular in the NHS, in the last 15 years or so, and it needs to be cut back down to size again, so I'd say in our service we're very much, we do look at… we're weary of the tail wagging the dog and that we're not just feeding the machine. The admin side is there to support the clinical, so yes, for service delivery, not the other way round"* (Daniel, 466-471)

Similar to Kevin, there is a recognition for a certain level of wastage or inefficiency in the system. Although accepting of the demands and rationale for this aspect of service provision, it is suggested that it be scaled down as it risks interfering with the primary task of delivering adequate treatment. Daniel is reluctant to place too much emphasis on the collection of administration, perceiving the repository of this information to be something unfeeling and non-sentient, thus in opposition to his role as a caregiver. Hence, it seems that dealing with these multiple and conflicting demands requires that Daniel reclaims what takes priority and what doesn't.

The tension in having to deal with these conflicting ideologies emerged at a very personal level. For Chris, the rationale underpinning the fast access, high-volume way of working in the IAPT programme was in direct opposition to the ethical values he had since incorporated in his work as a psychotherapist:

> *"my team are supposed to see five people a day, as a minimum, but then how do you then train them to a standard, and if new electronic systems have been imposed, that takes time to integrate so, but you've still got to see five people*

> *a day. So you know, and I know its, some IAPT services they see more than that, but it flies in the face of [British Association for Counselling and Psychotherapy] BACP and [British Association for Behavioural and Cognitive Psychotherapies] BABCP requirements, so IAPT says you must do this but actually the governing bodies that govern the therapies say you can't so"* (Chris, 527-532)

The tensions in Chris arise at multiple levels. The first tension revolves around the difficulty in having to accommodate for other duties which appear to be constantly changing. As new demands are placed on his service without added resource, attaining the original goals, for him personally, becomes challenging. The second point he makes is more contentious as he identifies a distinct conflict between two major forces in the psychotherapy landscape; the governing bodies versus the large-scale initiative that is the IAPT programme. Accordingly, he implies that if the demands of the IAPT programme are set to continue, then the disparity between these two forces will only expand with it, possibly leading to greater dilemmas among participants.

Differences in perspective were highlighted by Kevin, who refers to a conflict between a clinical and business ideology towards service provision:

> *"My own personal gripe is this is what the evidence base tells us, but we have business managers saying no, you can't have that, you know … get more PWPs, and you're thinking well hang on… you're a business manager and this is the clinical model"* (Kevin, 604-607)

This extract demonstrates a level of resentment in Kevin as the evidence base is ignored by individuals in favour of cutting down on costs. He is cautious that his ability to deliver the best quality of care and stick to what the evidence base advises may be at risk. This reflects other participants' concerns about the conflicts that can interfere with what is best for their workforce and incoming clients. Hence, the role of the participant in their present context means attempting to deal with these various pressures. Dealing with them requires that participants are firm, aware and mindful about what can and cannot be done.

5.7 Focus on Relationships

Participants explored their experience of the implementation process and operation of services in the context of their relationships with particular groups. This included the dynamics of the relationship with incoming clients, their relational and collaborative work with GPs and finally the inter-working practices among their workforce. These themes conceptualise the relational working that characterised much of the participants' activities, and how it had influenced the rationale for adopting certain practices.

5.7.1 Incoming Clients: Striking a Balance between Individual and Utilitarian Needs

One thing that was noticeable in the data was just how critical each participant considered the early stages with clients to be. It was generally accepted that depending on how well these stages were executed, this would ultimately determine a client's level of engagement and subsequent outcome. Beyond this stage, participants were confident that clients would most likely stay engaged as highlighted by Melissa:

> *"what our patients tell us that once they've got into the service and they receive therapy they are very positive about it. Where the difficulties lie still, is in accessing the service"* (Melissa, 281-284)

Melissa refers to a definite point in the patient pathway and in so doing elevates the importance of this particular moment. Her feelings about clients engaged in the service are of less concern and so the worry for them is reduced. Conversely, it is those who fail to move beyond the early stages that create a dilemma for her. She appears to feel confused as to why those engaged speak of their positivity about the service, yet there are those who fail to ever engage. Isabelle experiences a similar type of confusion highlighting her stance on being flexible to those who may not like the nature of their therapy; "*we try and accommodate*" (Isabelle, 197). Therefore, it seems unclear to both of them why anyone would ever dropout. Consequently, there is a sense of loss and disappointment that clients who do not engage are unwilling to

provide information about why. It also communicates the fact that participants feel as though clients are missing out in some way, implying that participants hold their interventions in high regard.

Reasons for this disengagement are contemplated by Gemma:

> "*any wait times or hiatus in their pathway tends to create a dropout, but also what we have been told from our service-user feedback sessions is that it is the lack of communication in those times that they struggle with… and because they don't know how long it's going to be. What they're waiting for, who they might see, that anxiety can build, and then when they suddenly come to an appointment being offered they kind of go ahhh… and then don't go pitch"* (Gemma, 225-230)

Gemma recognises it as a lack of communication regarding the nature of the therapy that causes the most distress for incoming clients. There is an understanding as to why clients disengage in this instance, leading to her feeling guilty that more could not have been done in the intervening stages. Taking on the perspective of a hypothetical client whose communication with a service is lacking, she describes an isolating and vulnerable experience that ultimately leads to a breakdown in trust. It is clear that this is an unintended consequence of how this service operates, producing feelings of unease in Gemma. In considering the response from Kevin, it is perhaps the perceived lack of relationship between a client and their practitioner. Indeed, Kevin and Mary both stress the importance of ensuring therapy is well-grounded on a strong and tangible relationship:

> *"we found that it really was a case of those that were engaging people well, and had high numbers through treatment, they'd put the emphasis on them, the relationship, and it was me that you'd have treatment with"* (Kevin, 268-270)

> *"they get somebody on the end of the phone straight away, and then they're engaged because once they've spoken to somebody, generally people are more likely to stay engaged"* (Mary, 438-440)

Regarding engagement, both participants conceptualise the relationship as being the most critical for the purpose of enhancing a client's commitment and motivation. The simple act of having human contact is perceived as paying dividends, with each emphasising the value of establishing rapport. The simplicity of this task and the fact that the message was getting lost in treatment delivery potentially led to participants feeling impeded or disappointed. However, their optimistic outlook throughout their interview expresses a sense of hope that now this message is known and made clear, practice will evolve accordingly.

The role of assessment was something where participants tended to differ in opinion about what its function was and how it should be conducted. All participants tended to see the value of conducting a more in-depth assessment for directing clients into an appropriate course of treatment: "*it's making decisions based on an assessment rather than an assumption*" (Gemma, 205). This topic also included who they believed should conduct the session in terms of practitioner experience. For Daniel, the solution was unequivocal: "*we believe that um… initial assessment is most safely and effectively and robustly carried out by people who are better trained, have more experience*" (Daniel, 39-40). However, Kevin was more compromising, using the initial telephone contact to make this decision: "*if it seems like it's a, sounds like it's a fairly straightforward IAPT problem, they will just go to an assessment with a PWP*" (Kevin, 45-46). Conversely, for Melissa, being able to use more experienced practitioners was considered to be unfeasible and did in fact seem like a luxury: "*the idea that you could use your high-intensity therapists to do assessments is just not, no you have to make full use of your workforce to assess*" (Melissa, 138-140). This impracticality is due, possibly, to the high level of demand and pressure placed on her service. Rebecca comments on this kind of pressure further, highlighting how it had impacted service provision: "*unfortunately it takes longer to do a face-to-face assessment, and we've had to make the compromise of quantity, to meet demand, and that means doing telephone assessments which I don't know, the jury's out*" (Rebecca, 489-491). It seems that there is little confidence in Rebecca about the current approach, conveying a feeling of apathy about her inability to change things. Returning to Melissa, it was clear that what she perceived to be important from the

client's perspective was accessing treatment sooner, and not having to repeat themselves over and over:

> *"what you're getting is, you're getting people passed from potentially two or three therapists, which is not a helpful experience. And you know, potentially repeating your story which is not a good experience*" (Melissa, 121-123)

All participants are sympathetic to the plight of incoming clients; however, they each view the role of assessment differently, rationalising their approach in different ways, insofar as to be practical. The demands of an IAPT style ideology seem to skew and mould how the assessment takes place, sometimes against a participant's better judgment. This influence perhaps makes for uncomfortable provision in participants due to uncertainty over the approach they are, in part, responsible for implementing.

Getting the course of treatment right in the first instance was perceived to be important. It was recognised that once a client becomes engaged it is difficult to try and then modify the treatment, as reported by Gemma:

> *"you can't always predict complexity until you're actually in treatment and then it's really hard to then step somebody up, once they're in treatment, so we do struggle with that"* (Gemma, 128-130)

It seems that the full nature of a client's condition isn't discovered until well into treatment, and by this point, they may already have formed an affinity towards the therapy and their therapist. Interfering in this process represents an intrusion and invokes uncomfortable feelings in Gemma. It is described as a continuing struggle, with no agreed upon approach as to how to overcome this barrier. Therefore, this has the implication of making the early stages particularly important so as to avoid this undesirable situation.

Interestingly, the initial stages and use of assessment were considered valuable for testing a client's commitment, as exemplified by Isabelle:

> "*the patient will ring up to opt-in, which tests their, you know, kind of commitment and motivation to what… towards therapy"* (Isabelle, 105-108)

In this example, the client represents a highly autonomous being who is entering into a contract of sorts. There appear to be terms and conditions or assumptions imposed by Isabelle, who is curious to figure out how likely this person is going to stay engaged. Elsewhere, when discussing those who are re-referring, having dropped out previously, she makes a similar comment about the purpose of the initial contact session: "*just test their commitment again I guess*" (Isabelle 367). However, it is unclear as to the purpose of testing a client's commitment and what the outcome would be if they were discovered to be uncommitted. Isabelle makes clear the openness and accessibility of her service, even going so far as to say: "*I don't think we turn anyone away to be honest*" (Isabelle, 273); with Gemma similarly echoing this sentiment. In a way, it represents a filtering out system from the perspective of the service so that participants can direct their efforts more efficiently. This approach is justified since those who are not initially committed can re-return when they are ready to do so, thus removing potential feelings of guilt.

Subsequently, this leads on to the topic regarding the impact of a self-referral pathway. Considering the dialogue so far, it was notable how the use of this pathway was reported by Rebecca:

> "*Fortunately or unfortunately, key for me, elements around the IAPT model is high-volume, fast turnover. And you cannot, you can't have the luxury of going round and round and round, and for me when the service moved to self-referral, really what we're doing is leaving the door open so, you know if they don't turn up today, discharge them tomorrow. They can self-refer again on Monday. So why are we sending letters out, you know? Just come back, when you're ready… There is… the risk is that you increase the revolving door, but it was always there anyway, all you were doing was deferring the inevitable*" (Rebecca, 241-247)

Rebecca's sobering thoughts demonstrate the difficulties in waiting for a client who is apparently uncommitted. She comes across as empathic, yet realistic about the current situation. Similarly, she does not want to impose pressure on the client. The nature of the IAPT delivery model creates an urgency in her that encourages the service to move on to the next individual who may be more committed. As a result of self-referral being available, she is not abandoning the client, but reclaiming her right and need to treat the needs of the broader population. This approach is similar to the use of a self-referral pathway being useful in the event of a follow-up procedure not being available, as mentioned by Melissa and Isabelle in their interview (see Constructing Service Effectiveness p.138). Daniel also captures this conflict: "*you need to strike that balance between individual needs and utilitarian needs of the collective masses that have been waiting to be seen*" (Daniel, 238-249), suggesting that the pressure to see as many clients as possible results in the initial and ongoing engagement with clients becoming problematic.

5.7.2 The Role of the GP

The role of and relationship with a GP constituted much of a participant's experience. It was clear that, aside from the relationship with a client, the role of the GP was critical to the operation and success of a service. As will now be explored, their influence was multifaceted and their position highly revered. Chris epitomises the importance of a GP within the realm of primary care psychotherapy provision:

> "*The key to psychotherapy starts and ends with the GP. Counsellors are very unlikely to step out people in assessment, they may be taking things on that they might not be equipped to do, so it's important that a GP gets it right when referring from the start*" (Chris, 649-653)

The GP therefore, represents an all-encompassing figure, integral to the process of incoming and outgoing clients. Their knowledge is perceived to be useful for improving the efficiency of a service. Similar to a point made in the previous subtheme (see Incoming Clients: Striking a Balance between Individual and Utilitarian Needs p.159), attempting to modify the course of treatment once a client

engages can be challenging. Here Chris is suggesting that with the help, expertise and authority of the GP, commencing treatment will be more streamlined and thus, easier to execute. It also characterises the role of the GP as a gatekeeper and protector of IAPT services. Accordingly, Daniel promoted this role even during the process of self-referral:

> "*it's managed self-referral in the sense that it's supposed to follow a consultation with the GP, as opposed to just somebody picking up a leaflet lying around in the waiting room somewhere and thinking, oh this looks interesting, then just referring themselves*" (Daniel, 19-22)

Again the value of the role of the GP is evident. The process of self-referral by simply picking up a leaflet is portrayed as being a matter of happenstance and not a particularly robust method. With the aid of the GP, he is far more assured in his approach. It also has the benefit of keeping the GP involved and communicates how positively their input and collaboration is valued.

The impact of self-referral on this relationship was similarly echoed by other participants. Each described the ways in which they attempted to keep their GPs involved, either in the initial contact with clients or when feeding back. Across the data, it was generally recognised that the use of self-referral had an impact on how certain GPs approached and engaged with a service. Mary elaborates on this:

> *"we were trying to make it easier for the GPs in that if their patients self-refer they haven't got to write a letter of, referral letter, which I think most GPs are happy with. We do have a few GPs who said that, but I want to tell you what I think, and we've said that's absolutely fine, you write to us then… We're hoping that by self-referral, we will get clients who don't want to tell their GP what's the matter*" (Mary, 64-69)

The intention of Mary's actions appears good-natured and sympathetic to the burden and pressures on GPs. She recognises that not only does self-referral stand to benefit the client, it also has the potential to make things easier for GPs. That said, there is an unintended consequence of taking this route as GPs who do wish to offer their

clinical opinion may find the process confusing. Although they are receptive to the judgments of these professionals, the means by which they now communicate this appears out-dated and possibly inefficient.

It is possible that participants may have preferred self-referral as it provides them with more control over their criteria for those referring into the service. GPs misunderstanding the referral criteria for an IAPT service created a challenge for participants. As already discussed, trying to incorporate those who do not fit the model can be problematic for delivery and the recovery rate (see Bringing Order to Disorder p.131). Melissa explores this issue further:

> "*to start with our GPs were not particularly clear about the referral criteria... we've had to engage in a fair amount of information sharing about the criteria. Most are okay now, but we still get GPs who employ a scattergog approach and just refer simultaneously to the local mental health trust and to our services, and GPs who refer patients who they find problematic, whether they are seeking psychological therapy or not*" (Melissa, 25-30)

This type of approach from GPs poses a risk to the function and efficiency of the service. There is an internal conflict in Melissa as she tries to empathise with GPs while also recognising the difficulties facing her. Fortunately, there is a sense of relief that the early challenges involved in engaging GPs have succeeded. Nevertheless, there remain a few GPs who are described as being somewhat cavalier in their approach and hard to manage. Melissa appears not to be blaming GPs but is instead concerned for those clients being referred, something that characterised much of her narrative. This feeling is perhaps why she has undertaken and looks set to continue her extensive engagement practice to improve their shared understanding. Similarly, the 'scattergog approach' may reflect something in Kevin's narrative. When recalling the process of implementing a single point of access, he refers to a previous delivery model with multiple referral points for specific services:

> "*GPs were really dissatisfied with that, they didn't care what good outcomes we were getting or whatever, they didn't like multiple referrals, multiple*

> *points of patients being put between services, and quite rightly so*" (Kevin, 470-475)

Kevin agrees with the request of GPs as being fair and justified. It could be that the confusion from the perspective of the GP may be due to a complicated process, and one that either requires the use of extensive engagement or model restructuring, so as to make the referral process more straightforward.

Isabelle also felt misunderstood by GPs but in a different way. Here she is commenting on the topic of waiting lists:

> *"Yeah, or you can send more, please send us more (laughs)*
> *GPs always have this kind of, I don't know where they get it from, this thought that we have massive waiting lists… but we don't. We're seeing people within 28-days, and we haven't got waiting lists, so you know, send them (laughs)"* (Isabelle, 601, 609-612)

Isabelle is pleading with GPs, albeit in a comedic manner, to send more clients. She seems puzzled as to where the idea of having long waiting lists has come from and is keen to rectify this misunderstanding. At the time of the interview, it should be noted that Isabelle's service was introducing a self-referral pathway that didn't involve the GP (unlike Daniel's service).

The fact that a GP is still so central to the survival and input of a service again conveys the role of the GP as being pivotal. It may also suggest that participants feel they are at the mercy of these professionals, although the degree of reverence each participant had for a GP would suggest otherwise. The process of engaging with these professionals was, therefore, a key activity for participants during the implementation process. Mary refers to a trend that: "*people who want to access psychological services tend to gravitate towards the practices where you've got doctors who are much more psychologically minded*" (Mary, 184-185). Consequently, this was described as having a direct impact on the relationships and links with GP practices as it risks skewing and favouring one practice over another. Similarly, Kevin recognised the value of positioning an in-house practitioner within

specific GP practices: "*so every therapist is actually allocated to specific GP practices, and the GPs love that, it's an engagement thing as well*" (Kevin, 325-326). Both these quotes identify the concept of having a presence and developing awareness in GPs about their service.

5.7.3 Orchestrating a Cultural Shift and Protecting the Workforce

The inter-working practices of a service were contemplated heavily by participants. Based on their accounts, it was clear that both they and their staff were coming to terms with a definite shift in the way of treatment being delivered. This concept was briefly touched upon in the subtheme 'Inheriting the Old Service' (p.150) and refers to the fact that practitioners, with their own expertise and ways of working, were already employed by the service long before the implementation of the IAPT delivery model. Therefore, this had the consequence of requiring a cultural shift in the workforce. Rebecca comments on this experience concerning the new emphasis on telephone assessments, itself determined by the fast access, high-volume nature of IAPT style provision:

> "*we did all our assessments face-to-face. And you know, that's been a big culture shift for the staff really, and I guess a compromise driven decision, quantity versus quality. You know, some staff feel really comfortable with it, don't really feel it's that much difference, some staff don't like it at all, really miss that face-to-face.*" (Rebecca, 479-483)

This extract exemplifies much of the narrative from participants regarding this topic. The decision to adapt was felt very much to be stimulated by forces beyond the service boundaries. At the point of implementation, there was an almost immediate contrast identified between each time frame in terms of treatment delivery and service objectives. Perhaps it was perceived that those outside forces making these requests did not understand the poignancy of this change. Rebecca demonstrates this by contemplating the balance between 'quantity versus quality', highlighting a shift in priorities and ideology. That being said, there is a degree of variability with how accepting the workforce were towards these new practices. Those in the workforce who were resistant or possibly even critical of these changes were often associated

with being the source of most conflict, given the pressures on participants to conform to this change.

Gemma emphasises the value in striking a balance between practitioners delivering treatment in different therapeutic modalities:

> "*we very much want to get it the same as, that the wait for CBT and the wait for counselling is the same. There's no, you know, sort of discrepancy. Yeah and it's all step-3, so it would be useful if it's all the same wait times for all of step-3*" (Gemma, 174-176)

Gemma's approach is undertaken possibly to secure fairness among the workforce and ensure that each intervention has an equal footing. Thus, when a client comes to making a choice about their course of treatment, there is consistency regarding the time to wait. Nevertheless, this may indicate something else about the status of therapies within the service itself. It was highlighted that where long waiting lists existed, it was often due to clients waiting for counselling services. Certainly, these waiting times are in conflict with the ideology of Gemma's service and indeed other participant's services, which is to deliver fast access, high-volume provision. It may explain Gemma's attempt to rectify this disparity and thus reduce her colleagues feeling disheartened or potentially even downgraded. Participants, particularly Isabelle, valued an eclectic approach when delivering treatment, so it is understandable why it was important to reduce any and all 'discrepancy' between interventions and promote equality.

It was also notable that several participants, including Gemma and Mary, Kevin and Daniel, each spoke of taking it upon themselves to make the job for their practitioners as interesting and worthwhile as possible. An example of this is described by Mary:

> *"we're not having people sitting just you know, on the phone, and I think that we don't, our PWPs don't just do that, because actually we want to keep them, and we want them to make the job as interesting as possible. And we want them to be an integrated part of the service, and we feel, and I think that*

if that's all they did that would be very difficult, and I think the fact that they do face-to-face clinics, then they can do a little bit of that, but it, it's not a pure model, it's our adaptation of the model" (Mary, 456-462)

Mary's behaviour suggests that the characteristics of the work involved may be at risk of being tedious or challenging. It is suggested that without intervening, the probability of losing practitioners, of whom they greatly value, would only increase. A monotonous task is understood to be associated with a pure and basic IAPT delivery model. Mary, however, encourages the workforce to engage with different treatment formats and also within the development of her service. You can sense the protective nature in Mary regarding her colleagues and in particular towards her PWP workforce. There is a need to create a sense of belonging and empowerment in these practitioners which would otherwise be missing. Similar to protecting clients in the assessment session by using more experienced practitioners (see Incoming Clients: Striking a Balance between Individual and Utilitarian Needs p.159), it may also act to protect practitioners themselves, such as those with less experience: "*it might not be very fair to put this person in front of a PWP*" (Kevin, 43-44). Thus, the implementation process for these participants includes protecting colleagues from negative experiences such as stress, weariness and animosity.

In keeping with this concept, the art of protecting colleagues also meant ensuring that each of them were suitably qualified to fit within the scope of IAPT-approved therapies, as illustrated here by Isabelle:

"every person who is in this service has got an IAPT qualification. So even the counsellors that came to the service that were just.... I say just, but that's not right… um... but were generic counsellors, have all been through counselling for depression courses. So our psychodynamic therapists have all gone through the [Dynamic Interpersonal Therapy] DIT, yeah, so, and we've done mindfulness and [Eye Movement Desensitization and Reprocessing] EMDR, so everybody has got an IAPT qualification, in the service, one or two (Laughs), in actual fact, yes yes" (Isabelle, 303-308)

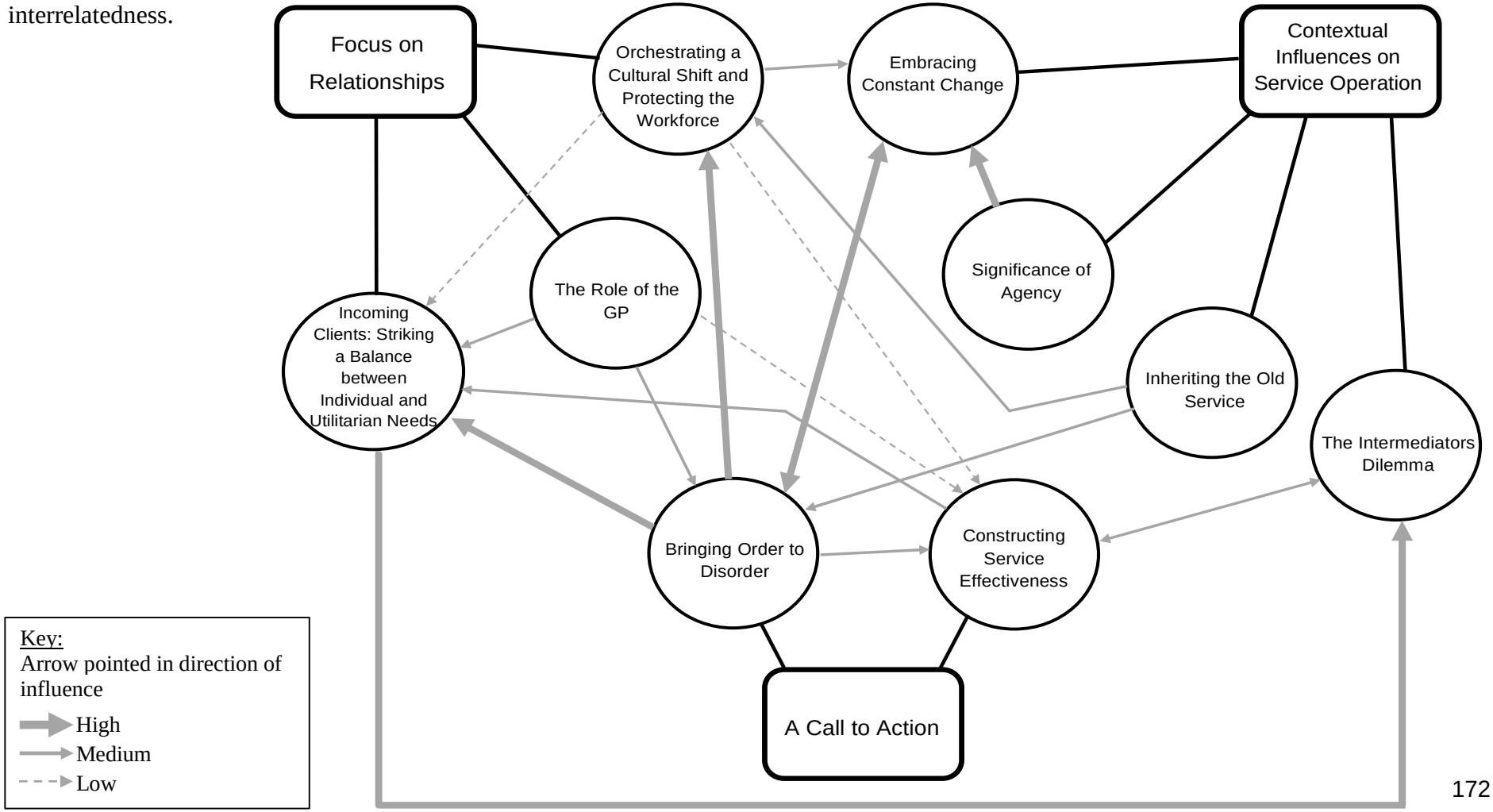
Isabelle slips up in her speech about referring to generic counselling with the word 'just'. She is quick to rectify this slip, but it is visible that without IAPT approval, counselling could potentially be considered of less worth. This kind of IAPT emblem of approval is also applicable to other interventions when looking at this quote. Isabelle makes a point that every member is equipped with 'an IAPT qualification', even going so far as to suggest some have two. It may be that she is simply striving for all her practitioners to be trained to a high-quality level. However, it may be possible that she perceives their roles as under threat unless they carry this badge of approval. This idea finds support in the comments made by Rebecca, who being from an 'IAPT-light' service, perceives an inevitable shift towards full IAPT-compliance for all primary care mental health services:

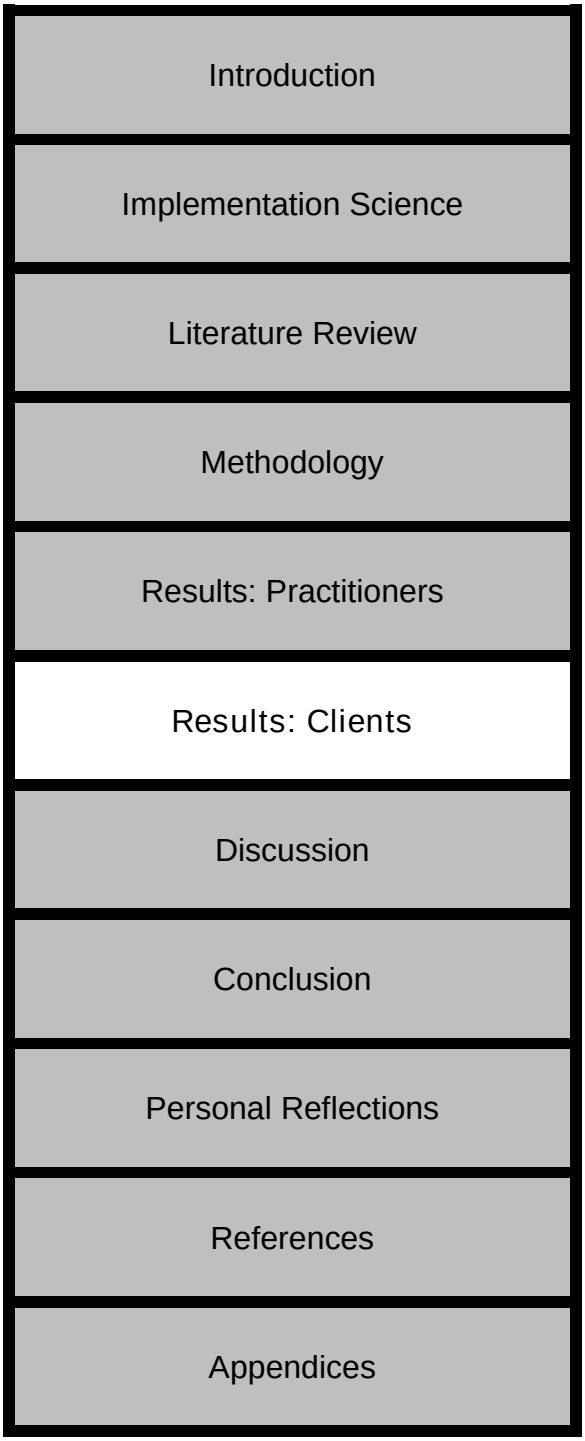
> *"in terms of our training, plan if you like, training strategy is really the IAPT training, high-intensity, low-intensity. There seems little value in really, you know sending people on other courses, it's the national standard, it's a good quality training, and it's all going the way of IAPT… it's where all the money is currently. Huge investments, it's the only place that is gaining investment in all of mental health."* (Rebecca, 278-284)

It should be noted that Rebecca too considers the training accompanying IAPT to be of the highest quality, revering it greatly. That said, there is a kind of defeatist attitude in her, believing all other avenues to be irrelevant in light of the immensity of the IAPT programme and its influence.

Figure 7: Practitioners Delivering and Implementing Services: Diagrammatic Gestalt of the Themes and their Interconnectedness

Given the interconnectedness of the themes, I have compiled a diagram about how each subtheme is related to one another by way of influence and the strength of that influence. This technique, I hope, will aid in the comprehensibility of the findings by illustrating the subthemes' interrelatedness.




Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

6 Results: Clients Engaging with Services

6.1 Introduction

This chapter outlines the qualitative analysis I carried out using an Interpretative Phenomenological Analysis (IPA) approach for clients who had engaged with an Improving Access to Psychological Therapies (IAPT) service. Each theme is then discussed with supporting quotes from participant's data, referenced using the format: "*Quote*" (Name, Line Number of Quote in Transcript). See Appendix 11.8 for transcript key.

6.2 Participant Overview

All participants either chose or were assigned a pseudonym:

"Rachel" is a college student. She received six sessions of group therapy based on a Cognitive Behavioural Therapy (CBT) model. She has had many psychotherapeutic encounters before this, including Child and Adolescent Mental Health Services (CAMHS) based counselling, hypnotherapy and group therapy courtesy of a mental health charity. She self-identifies as having depressive and anxiety related problems.

"Michelle" is a retiree originally having worked in the National Health Service (NHS) for many years. She received a low-intensity CBT-based intervention. She has had counselling on and off for the last seven years and has been receiving treatment in other areas of the NHS due to an enduring physical health problem. She self-identifies as suffering from depression.

"Sarah" has a background in dentistry and now works one day a week. With the service, she has received six sessions of low-intensity treatment which included five sessions of face-to-face CBT and one session of group therapy based on a CBT model. It is her first experience of engaging with psychological therapy. She self-identifies as suffering from depression.

"Kate" is unemployed. She was engaged in a psychoeducational group based on CBT, lasting for five sessions. She self-identifies as suffering from depression and anxiety but chose to concentrate solely on her depression during her engagement.

"Maria" is an Urdu speaking female who required the use of an interpreter. She self-identifies as suffering from depression, panic attacks and psychosomatic symptoms. She was the only participant to have received high-intensity treatment although she could not reliably recount how many sessions she had received.

"Trevor" is employed as a person-centred counsellor. At the time of the interview, Trevor had yet to engage with therapy due to a prolonged access into the service. However, he had first-hand experience of engaging with an IAPT delivery model; thus, his experiences were judged to be of value. He had been prescribed General Practitioner (GP)-based counselling. He self-identifies as suffering from depressive symptoms from time to time.

"Felicity" is self-employed. She originally received three sessions of person-centred counselling before being stepped into low-intensity face-to-face CBT for five sessions. She self-identifies as suffering from anxiety and psychosomatic problems.

All participants had completed their course of therapy within the last month, except for Trevor, who had yet to start, due to a prolonged and difficult access.

Appendix 11.6 provides further information on these participants.

6.3 Services Still Participating

Three of the IAPT services from the first study of the project also participated at this stage. These services represented that of Kevin's, Daniel's and Gemma and Mary's, with the other two IAPT services declining. One IAPT-light service agreed to participate, but, unfortunately, there were no participants recruited from here.

6.4 Master Themes and Subordinate Themes

Three master themes emerged from the qualitative analysis, with nine supplementary subordinate themes (Table 9). Although the analysis presents these themes independently, all were felt to be interrelated.

Table 9: Master Themes and Subordinate Themes for all Participants in the Client Sample

Master Themes	Subordinate Themes
A Personal Journey: From Discovery to Advocacy	Navigating the Unknown
	Surviving the First Stages
	Feeling a Connection in Therapy
	Sense of Duty and Responsibility
Perception of Self	Finding the Right Fit
	How the Service Sees Me: Including Challenges to Identity and the Role of Language
	The Enabled Self: Validating Recovery
Outside Factors	The Role of Others
	The Necessary Journey

6.5 A Personal Journey: From Discovery to Advocacy

This theme explores the ways in which participants made sense of their experiences in the context of a personal journey, from discovering the existence of a service through to advocating on its behalf. Each stage was characterised by a range of different emotions and behaviours as participants slowly progressed throughout each one. Their journey involved pushing beyond several perceived boundaries, with each staying engaged as a result of a felt sense of duty and responsibility having gained the opportunity to access a service.

6.5.1 Navigating the Unknown

All participants referred to the stages in advance of accessing a service with a sense of uncertainty. This feeling often stemmed from their experiences of being in between services, which were often characterised by feelings of isolation and being unsure in themselves and of where to turn. Trevor's narrative highlights this concept further:

> "*it was a lot of my own, I was a little bit tentative. I met a female GP and when I, and I don't use GPs very often when I go, and she was very tentative, I felt. Did I tell her my background? Don't know, but it was very like, well if you give them a call and good luck with it... Which is nice in one sense, but in another it's like well off you go. Good luck with that, and one thing that has just come to mind actually is you've got to have again, quite a strong value in what you need for yourself, again at a time where I'm not sure your self-value is particularly high*" (Trevor, 89-95)

It is clear from Trevor's perspective, there is a great deal of self-conviction and self-agency required in considering his access to a service. He perceives this as a contradiction as these qualities are at their lowest during this period, describing his value in himself to be diminished. Thus, not only are participants navigating the unknown regarding services, but they are also uncertain in themselves about what their needs are. Trevor later refers to his uncertainty about what type of service is right for him, possibly resulting from how long he has suffered from his issues (see

Finding the Right Fit p.195). Without the guidance and support from health professionals, further compounded by his self-doubt, this may explain his prolonged suffering. For Trevor, the actual act of going to the GP represents a landmark in the acceptance of his condition, with him clearly explaining that he does not 'use GPs very often'. Therefore, the response he gets appears to disappoint him, leading him to feel neglected and his behaviour undervalued. His comments about his GP wishing him good luck appear cynical, as though they have relinquished responsibility for him. Consequently, this conveys a feeling of abandonment and potential disillusionment during this period. This feeling of abandonment was also described by Rachel when discussing her transferring from CAMHS into adult services:

> "*I've just been in between services, kind of on my own really, like I'll go to other things like this, but I don't know*" (Rachel, 235-237)

Similarly, Michelle speaks of a kind of injustice that the roles between her and her GP had switched:

> "*I've had to discover that, and I think that by my going back to my GP and saying this is what I've discovered, that's not the right way round, the patient does not go and tell the doctor*" (Michelle, 324-326)

The implication being that from her perspective the health professional no longer coordinates her care and supports her adequately enough, thus she is forced to navigate services without sufficient insight.

When considering GPs, it appeared that their role was particularly influential in participants' experiences of feeling isolated and uncertain throughout this period. As already discussed, Michelle and Trevor each spoke of their disappointment in feeling abandoned by their GP. Michelle makes admissions for this practice, recognising that: "*to me GPs are so rushed that they're not really joining the dots*" (Michelle, 295-296). Felicity comments on this topic further:

> "*My GP didn't ask me very many questions actually, in fact, my feel of GPs these days is, and this is probably very generalised and you'll laugh at me, is*

> *the fact that they're very happy to throw drugs at you rather than send you and assess*" (Felicity, 77-79)

Felicity's extract characterises the perceived role of the GP as being too busy for participants to coordinate their referral and access into a service. Felicity's account suggests that support and guidance for her were largely absent, perhaps increasing her feeling as though she was navigating the unknown. Upon receiving the recommendation from a friend (see The Role of Others p.206), Felicity approached her GP about potentially accessing the service. However, her approach required a certain level of persistence as highlighted here:

> "*I was determined to be referred, so I was almost asking him, please refer me, because I've had drugs and they're not working*" (Felicity, 99-100)

This quote suggests that navigating these stages is also about convincing the GP that she is worthy of a referral, seemingly almost pleading with them. Consequently, it further supports the concept that pushing beyond the unknown requires a great deal of self-conviction.

Contrasting this experience, Sarah spoke of her appreciation for the role of her GP in publicising and encouraging her to access the service. Maria too refers to a poor awareness about services:

> "*Awareness is quite low. There is a lot of ladies who suffer after pregnancy, and they keep going to the doctor, but they should be aware of it, that there is a service, so they can use that service rather than keep going to their GPs*" (Maria, 246-248)

For Maria, her lack of awareness had meant needless contact with her GP, suggesting that she believes her suffering had continued unnecessarily. She also suggests that the GP could play a key role in improving awareness about IAPT services: "*Best thing is, teach GPs, GPs should know more and refer quicker*" (Maria, 252). Accordingly, this helps to highlight the value of the GP in helping participants

navigate the unknown, particularly at a time when their self-value and awareness is low.

Improving awareness about services was especially important for Sarah. It seemed that a lack of it had the consequence of creating many negative preconceptions that almost jeopardised her approach towards a service:

> "*I didn't know it existed. I think that's probably something they could improve on is the advertising, poster in the GP office or something. Because I didn't know anything about it, to be honest, as I say I thought I was going to go see somebody like um... a mentally trained nurse that would be sitting there analysing me, and that's what I thought it was about. I didn't realise that I would be given sheets and yeah... Challenging the perspectives and general consensus would be really quite good as well because I was actually dreading it, I was expecting somebody to be there in a uniform and she wasn't*" (Sarah, 365-371)

Sarah's comments convey a sense of fear and anxiety about what she might be letting herself in for having committed to therapy. It also appears that these preconceptions were not challenged up until actually accessing a service, suggesting that the information she had in advance of this was limited. As indicated elsewhere in her interview, much of Sarah's experience during these stages were characterised by denial and avoidance up until a point of crisis (see Surviving the First Stages p.182). She imagines a situation that is uncaring, believing she will be subject to judgment from a practitioner. Similar to other participants' experiences, the feelings and emotions associated with this stage are particularly negative and seem to stem from a lack of awareness and support in the intervening stages. Sarah's comments about the 'general consensus' highlight that these expectations are deep-seated in her perception of society. Comparably, Felicity recognises that others may be suffering unnecessarily, due to a lack of awareness about their condition:

> "*I do think there's lots of people who will need counselling who never thought in a million years they'd need counselling, which was me… I've got lots of friends who work at a very high level, who would never dream of*

> *going for counselling but probably needed it more than me*" (Felicity, 490-493)

This lack of awareness about services, alongside feelings of isolation and fear of abandonment from health professionals, represents an unknown and difficult transition for participants at this stage. These factors may make things more problematic for those suffering with a Common Mental Health Problem (CMHP) as the ability to navigate the unknown may be severely impacted by their condition, as shown by Kate:

> "*I was suffering from anxiety and depression really bad. I didn't want to do nothing, I was letting things get on top of me, I was snappy, grouchy, and I had every single symptom"* (Kate, 168-170)

Trevor had a troubled and turbulent referral process into a service with his progress impacted several times. Here he reflects on his experience and highlights again the drive and determination required in finally accessing a service:

> "*Yeah, well the service-user doesn't really drive this at all... in my experience, the service-user struggles to get a toe in the door, and then when it does, you've got to keep it there for a while, because again I would say without trying to be cynical, it shut several times. You've got to keep opening that door, a lot of barriers to overcome*" (Trevor, 195-198)

Trevor uses a metaphor of an actual door being shut, encompassing his struggle to reach the service, but also highlighting his determination 'to keep opening that door'. Potentially, this is to describe the pain and anguish he has endured during this period. It is also with a sense of irony that he describes this process. At a time when he feels his most vulnerable, confused and isolated, accessing the care he needs requires that he stays resilient, convinced and accepting of himself.

6.5.2 Surviving the First Stages

Participants characterised the initial stages of service engagement as something to overcome, perhaps even survive, to be able to access treatment. Each spoke of several difficult encounters when first accessing a service, perhaps influenced by their uncertainty, denial and isolating feelings that had characterised many of their prior experiences (see Navigating the Unknown p.177 & Finding the Right Fit p.195). For Trevor in particular, it seemed that making it beyond these barriers were worthy of praise by and of itself:

> "*I'd rather see results measured by, with reference to the amount of people who need the service, rather than the amount of people who survived the assessment process*" (Trevor, 255-257)

It is important to Trevor that he be recognised in making it beyond the assessment stage, representing it as a challenge that he has overcome. He describes it as being something to survive, therefore perceiving the process as a sort of purging exercise, eliminating those who are uncommitted, or possibly even weak. The fact that this is overlooked leaves Trevor feeling unappreciated for his efforts in making it this far.

Other participants expressed a general reluctance to engage, contemplating their withdrawal early on, highlighting their heightened sensitivity during this stage:

> "*I didn't want to go so I wasn't bothered about waiting, that really didn't bother me because I really didn't want to access the service anyway, I thought oh, no, not keen*" (Sarah, 21-22)

> "*it's like if you've got somebody who's got anxiety or depression they don't want, they've planned their exits*" (Kate, 296-297)

The type and use of questioning were considered to be particularly impactful and difficult to answer. For Sarah, the initial stages were a challenging time, made worse by the type of questioning used:

> "*I didn't like it at all, I didn't like the questioning, because I was having to talk about things that I didn't really want to talk about and I didn't like that. But I knew it has got to be done really to assess how they need to help me really. I can say that now, but at the time I wasn't really in the best place to talk about it*" (Sarah, 68-71)

Sarah accepts that these questions were necessary to allocate her to an adequate course of treatment. However, her experiences in the build up to accessing the service involved a level of denial and avoidance about her condition. Therefore, when it came to confronting these issues, she felt sensitive about what she had to confess. The information required and nature by which the service sought to uncover this left her feeling emotionally raw.

The type of questioning used also carried the risk of presuming or proposing to a participant how their condition would develop as highlighted by Maria: "*the questionnaires were like, would you self-harm or things like that, so that made me feel like over and over that's what is going to happen with me*" (Maria, 41-43). Felicity similarly raised this point: "*questions were quite hard reaching, some of them were, are you going to cause physical harm to yourself, and I appreciate that they've got to ask all those, but I thought, whoa this isn't me*" (Felicity, 505-508). Surviving the first stages meant pushing beyond personal vulnerabilities and anxieties about what the service was insinuating. For this reason, initial engagement proved problematic.

The issue was further enhanced as practitioners, with whom participants were engaging, were essentially a stranger. This situation created mixed feelings in Rachel:

> "*it was a bit sad because they were asking very like forward questions about it, and you're there telling a complete stranger, but then, I don't know, it was quite easy because you know the answers but... questions were quite emotive, some of them made me a bit emotional*" (Rachel, 40-42)

Rachel implies that it is more difficult for her to open up to someone whom she considers being a 'complete stranger', in spite of the practitioners intended role as a close confidant. Again the questioning used left her feeling emotionally drained, similar to Sarah and Maria's accounts. As each participant is accepting of the need to take this line of questioning, it represents a rite of passage and leap of faith that in answering these questions, or engaging with these uncomfortable feelings, they will be granted access to the treatment they desire. This concept refers to the feeling that the initial stages were about pushing beyond barriers, something that was made more difficult by the fact that they felt vulnerable in doing so.

Another factor impacting on this process was the use of a telephone for initial assessment. Overall, participants disliked the use of the telephone for their therapy (see Feeling a Connection in Therapy p.186). However, during this stage, participants were required to accept this format and this was met with a mixed response. For Sarah, the use of a telephone provided her with some anonymity, making her feel more comfortable regarding her initial engagement:

> *"No I didn't think I did want to be face-to-face, I think I did want to be, I wanted it to be anonymous really. Because I didn't really want to do it in the first place, I'm just glad it went that way*" (Sarah, 54-56)

Whereas Rachel contemplated both the positives and negatives about its use:

> "*I don't know because I get quite nervous about talking over the phone, so when we first rang up my mum had to ring and like arrange when they rang me and stuff, so I did kind of prefer talking face-to-face, but then again it was easier to answer some of the questions not having to look at someone. So it was quite good, you just had the voice. So it's got pluses and minuses to it*" (Rachel, 46-50)

Both accounts refer to an issue of speaking with someone face-to-face about certain issues, leading them to feel grateful for the distance the telephone provides. However, this distance does require greater motivation, or in Rachel's case, the help of another person in encouraging her to take up this opportunity. Elsewhere, Sarah

refers the service as a safe space away from home (see The Necessary Journey p.210), contradicting her appreciation for the telephone as it places her in this distressing environment. Trevor, perhaps concerned about his long and unpredictable journey into a service, was reluctant to open up via the use of a telephone:

> "*if I rip that plaster off in a telephone conversation and then get told you've got 14 weeks to hold on to that, good luck with that. Because had I said something, had I said I had suicidal ideation, which I don't, but presumably I would have been fast tracked into a service. But I would have still been left with that, nobody was there too, and they would have probably wound up by saying, are you okay, are you safe? Are you whatever? Yeah and I suppose this is all guesswork, but there's that thing of, regardless of what you say in that assessment, I can't imagine you're getting your session within the next 3 or 4 days, at best you might be getting 3 or 4 weeks, so what do you do with that? What on earth do you do?*" (Trevor, 140-148)

Trevor is referring to a metaphorical plaster, revealing a wound that would be at risk of never healing. His narrative is difficult to follow as he seemingly transports between different contexts and outcomes during his account, possibly reflecting the impact of his distress in the matter. He speaks of feeling detached and isolated leading him to remain guarded. It appears to limit his willingness to open up and reveal the true nature of his issues for fear of being without adequate support. His tone grew increasingly desperate and irritable during this moment, indicating his disappointment in the service about its approach. It is clear that he perceives the service as somewhat naïve, recognising that it can be easily tricked. He also suggests that it fails to acknowledge his need for defence mechanisms, identifying that they might expect too much of him. Earlier he speaks of being explicit with the practitioner about his sensitivity stating "*I'm not comfortable with that on a telephone*" (Trevor, 134), further conveying his distress due to the perceived pressures on him.

6.5.3 Feeling a Connection in Therapy

In analysing the data, it was apparent that much of a participants' experience could be symbolised as a longing for connection, support and understanding. Feeling a connection in therapy was emphasised as being a key factor in motivating participants throughout service engagement. The successes of treatment were often linked to a therapeutic relationship that was cooperative, personalised and encouraging. Among all participants, there was a general reverence and gratitude towards their therapist in light of feeling this connection. All participants greatly admired each practitioner they came into contact with, seemingly captivated by their skills:

> "*the [Psychological Wellbeing Practitioner] PWP who did it, she was great, I was impressed with that, and I made her aware of that*" (Trevor, 40-41)

Trevor's behaviour about letting his therapist know how highly he regards her is not necessary, yet he does so regardless. Consequently, it highlights the value he has for her, perhaps as a result of being understood. This concept of being understood was often linked to feelings of connection and insight in therapy as exemplified by Michelle:

> "*they took on board what I was saying, I was listened to, they understood what I was saying, but I dare say that they understood a bit more about what I wasn't saying, and they were able to gear it appropriately... Yeah, I think it's just having the staff to do the job, people who know what they're doing and who are able to cotton on to where you're at and yeah put the right measures in place*" (Michelle, 507-511)

There is great value in being listened to and understood for Michelle although, in the early stages at least, there appears to be greater value in what is not being said. Michelle speaks of being understood when she at the time failed to even understand herself. By feeling connected to her therapist, she can gain new insight in which she places great worth. She represents her experience as a journey, unclear of where she

is at, although with the skills and expertise of the practitioner, she can locate where she is in herself and personalise her treatment accordingly.

Sarah spoke of having initial doubts regarding her therapist:

> "*The first time I met her I thought, mmm not, you know when somebody just walks through the door, and you think, mmm not quite sure. But after the first session I really did like her a lot, yeah... I think it was better that it was a female for me really, yeah I think so. And she just, she just talked to me… and I mean I did cry, and all that sort of thing and she said look it's entirely up to you, if you don't want to do it you don't have to do it, you either put as much into this or as little… it's entirely up to you, but there is only me who could do it, and I thought oh God. But you know it was really good, and I felt quite in control about the whole thing*" (Sarah, 130-136)

Given her lack of awareness and knowledge about services, as well as her reluctance to engage initially, it is possible Sarah started her therapy with a negative bias. Despite her initial reservations, she can re-evaluate her expectations and develop a connection, identified by her appreciation for seeing a female practitioner. There is a notable emphasis on Sarah in all of this, with repeated use of personal pronouns highlighting her role in the relationship. This level of attention may help increase feelings of relatedness and, therefore, allow her to be more trusting and confident in what the therapist helps her to discover about herself. Sarah placed great value in this relationship, later referring to it as a source of inspiration:

> "*I looked forward to seeing her every other week really, and she inspired me to do the things really, and that was important*" (Sarah, 156-157)

Similarly, Rachel refers to a feeling of excitement regarding seeing her therapist, although for her, this creates the risk of portraying herself falsely:

> "*whenever I went to see my counsellor, I was having a good day because I was going to see her, so when I'm up I find it hard to talk about when I'm down, whereas sometimes I forget when I've been down, because my brain*

blanks it out a lot, so I don't know if she thinks that I was okay then, but I guess it got better" (Rachel, 241-244)

This feeling of excitement leads Rachel to not being her true self as her mood is significantly altered. It was clear throughout her experience that Rachel often found it difficult to be honest about concerns she had regarding her therapy, earlier stating that "*I didn't want to tell them I suppose*" (Rachel, 224). It is perhaps due to this positive feeling and the admiration for her therapist that lessens her concerns about the nature of her therapy. If it is not her true self in therapy, then it is not clear how this connection has manifested. Rachel is certainly in high spirits about her therapy and therapist, suggesting there are multiple means to feeling this connection.

Maria describes the essential qualities of the therapist, insisting that without them, therapy would fail to progress:

"*I: It doesn't make any different, she's Asian, or the other one, they have to be nice people, that will listen to you, they have to be polite, that's the most important. Because if I feel lonely, scary, nice people is face-to-face, more people will help.*

R: And how did your relationship with your therapist influence your time here?

I: She was nice, the thing is she guided me, and for me good things, positive side, like dress up, stay fresh and you've got your children, you need to look after them, she says, were really helpful. Good talking to me." (Maria, 297-305)

Feeling respected and understood were powerful factors in encouraging continued engagement among participants. Maria disregards all other factors as meaningless if the basic civilities of the therapist are lacking. These qualities counter the uncomfortable feelings of isolation and fear, something a strong relationship is perceived to help overcome. The therapist is successful in drawing on other relationships for Maria to relate to, encouraging her to recognise her

interconnectedness among others, perhaps to decrease her feelings of isolation, mentioned elsewhere in her interview. This extract and the following one from Rachel refers to the way in which the therapist talks with them:

> "*if they were quite stern and strict I just wouldn't want to listen, because I'd just shut off. And then if I come from college after learning all day, and if I was to get another teacher, but no she spoke to me like I was just, she was just trying to help us rather than talk at us*" (Rachel, 199-202)

It seems that how a participant was spoken to had an implication on how the role of the therapist was perceived, not in a position of authority, but on a more personal and intimate level. Thus, this is indicative of a more relational learning process where each party is seen to have an equal status. Consequently, it appears useful in supporting the participant to develop insight into the meaning and connections in their life. Therefore, the qualities of the therapist and the therapeutic relationship appear to play a role in understanding the concepts explored in therapy. Thus, the service is successful in creating a platform for the relationship to develop, supporting the participant in self-discovery and allowing them to identify feelings of connection elsewhere in their life. It also represents the process of relatedness and self-discovery as a dynamic and nonlinear process.

As already highlighted, the format by which participants interact with a service can have an impact on their experience and openness in the early stages of access (see Surviving the First Stages p.182). In respect of this theme for feeling a connection in therapy, participants further considered the use of an over-the-phone format for receiving their treatment. Michelle, Maria, Rachel, Trevor and Sarah all agreed that this format could lead to them feeling more disconnected. Michelle elaborates on this concept:

> "*I think face-to-face is better for me because, when… I don't know, you can just judge the whole situation better I think. I think you're on the phone you can cut-off the emotions that you need to deal with… if you're with a person, you tend to find that, that person is a support to you for that moment, and somehow it seems to be a better way of guiding you through that moment*

> *when you've hit rock bottom, in order for you to come out of it. I think if you put the phone down, which it is very easy to do because you've got to a very bad place, there's nobody there to come get you out of it. Telephone can be a bit impersonal, you know, for all I know, I'm sitting on the phone crying my eyes out and the other persons going at the other end, I'm texting my mate, you know, you don't know do you, I mean they shouldn't be but, yeah (laughs)*" (Michelle, 142-151)

Michelle's account is fairly typical of all those who raised a concern about the use of this format for receiving therapy. The following phrases are drawn from several other participants regarding this topic: "*phone is scary, face-to-face is better*" (Maria, 117); "*I get quite nervous about talking over the phone*" (Rachel, 46); "*I'm not comfortable with that on a telephone*" (Trevor, 132); "*always face-to-face, and when I was doing that yes I thought it was, it was easier to talk to someone*" (Sarah, 173-174). All describe negative feelings about the use of a telephone, potentially threatening their feeling of connection in therapy. The situation for Michelle is described as being highly impersonal, mechanistic and isolating. For these participants, feeling a connection in therapy also requires perceiving a physical connection. This connection is useful as a means of support during the occasions where participants feel as though, as Michelle describes it, 'hit rock bottom'. This metaphor links the feeling of connection with the ability to be lifted up. Furthermore, there is an element of mistrust about the therapist when using the phone, as they could potentially be doing anything on the other end. Although Michelle is quick to laugh, recognising that what she is saying is highly unlikely, it does give an indication of her thought processes during engagement, notably regarding her tentativeness, sensitivity and suspicion. As already highlighted above, Sarah appeared to enter her service with a negative bias, leading her to be sensitive about the connection she had felt towards her therapist. It could be that with the use of a telephone, these impressions are not easily challenged, resulting in her feeling more disconnected and disengaged.

Sarah raised a concern about feeling disconnected once her treatment had come to an end, due in part, to there being a lack of follow-up:

> "*I think probably the worst thing is that when it comes to an end, and it is up to you, well I know I can re-refer myself again. But I perhaps would have liked to go back in 3 months time, or, just a follow-up. It's like when you've had cancer treatment, just to make sure you're still, you know? I think that's missing, although I know it's very limited because I know there's a lot of people with problems really*" (Sarah, 305-309)

Thus, it appears that the feeling of connectedness in treatment and towards the service is lost soon after discharge. By drawing on parallels in other health settings, Sarah considers this to be an oversight and possibly unfair on her. In all aspects but this, the service has been accommodating to her needs and surpassing her expectations. However, in respect of a follow-up, she is left wanting and noticeably disappointed. This experience likely links back to feeling isolated in the intermediary stages between services (see Navigating the Unknown p.177). Although Sarah realises she can re-refer, the task of doing so seems excessive. Furthermore, it diminishes the role of the service in her road to recovery.

6.5.4 Sense of Duty and Responsibility

Participants linked their experiences of a positive service engagement with feelings of duty and responsibility. This behaviour refers to the attitude that participants described when considering what was needed of them to secure a place within the service. As already discussed (see Surviving the First Stages p.182), during the initial stages participants were required to confront many uncomfortable experiences, sometimes in what felt like isolation, to gain access to the treatment they desired:

> "*there was a couple of barriers, like you had to ring up first and book an appointment to have them ring you then go through that and then wait to hear what they said. Like when they had to assess all the answers and stuff, but then it makes sense why they do that, so it was yeah, it was okay*" (Rachel, 60-63)

As evidenced by Rachel, participants understood why certain practices were implemented from a logistical point of view. Her quote also demonstrates how participants tended to take on the perspective of the service to understand and accept situations where provision was less than ideal, such as having to endure long waiting lists (over four weeks). All participants, apart from Trevor, were generally forgiving of the service in these instances: "*everybody's got their own way of doing things, which is fine*" (Michelle, 320-321); "*I had to wait a couple of months before, but that was like my fault as well*" (Rachel, 23). Trevor was perhaps less forgiving as his journey into a service was descriptively disorganised and chaotic, culminating in him feeling disappointed and frustrated (see Navigating the Unknown p.177).

In many cases, participants spoke of feeling greatly motivated, due in large part to considering the therapy as being a prized opportunity. Sarah elaborates on this:

> "*I knew I had six sessions, I've got to get everything I can from this, even though I did feel as bad I did, I was so bad that I had to get myself out of it really, and that was the chance I'd got and it was up to me to do that really. And after I had that first session I thought yes, I can do this because she sort of motivated me to do it really. Just within that first session really, and then just laid out a plan going forward. If it would have been more sessions I don't think I would have got as much out of it really, I would have perhaps, perhaps some people do need more, depends how much they want to get involved... I mean they said six sessions so I thought that's what I've been allowed, but I thought yes, I'm going to go for this and get everything I can out of it*" (Sarah, 253-261)

The limit of receiving six sessions cements Sarah's judgment that her time with the service is precious and hence should not be wasted. Contemplating receiving more sessions leads her to suggest that it might have diluted her motivation in therapy. Perhaps this is driven by a lingering desire to move to recovery as quick as possible. Interestingly she uses the word 'allowed' as though she is now worthy of treatment; the caveat of this being to prove her worth in engagement. For Sarah, the key to successful therapeutic engagement means giving yourself completely to the service,

running counter to her desire to remain anonymous in the early stages. Therefore, the service is successful in allaying her doubts early on once she discovers what treatment involves, thus boosting her confidence in her capacity to engage fully with the service.

Rachel too highlights the concept of considering her time with a service as a prized opportunity. She motivates herself by recognising the many others who are in waiting:

> *"There's a lot of people who would want that opportunity, I wouldn't want to just not come and stuff. So I felt some sort of responsibility, because she is trying to help me so why would I not want to go"* (Rachel, 92-97)

Rachel highlights the level of appreciation participants referred to about accessing a service, which in turn enhanced their sense of duty and responsibility. This is important as ongoing engagement required a great deal of commitment, with participants sometimes considering what else they could be doing with their time:

> "*I suppose that from a personal point of view the least satisfying part of it is, oh you've got to go anyway, oh you should be going, and you could be doing something else on this fine afternoon*" (Michelle, 491-493)

There was a general resentment among participants when imagining those individuals in the service who may not be committing themselves as fully as they had done:

> "*perhaps they don't want to do the homework and things, perhaps it's not what they thought, you see it was totally different to what I was expecting, so expectations... Perhaps they don't want to do the thing on their own, perhaps they're thinking that if they go to see somebody they will be thinking that she's going to put… or he's going to put everything right for them. But I think it's on your own head be it, you're not going to stay with the service forever, you need to get out there and test it yourself*" (Sarah, 437-441)

Perhaps this is due to the value they place on the service. When people are less inclined to engage, they are perceived as failing to understand what is required of them. From the perspective of the participant, if they are unable to fulfil this duty, they are not worthy of this opportunity. It is implied that these other individuals are merely expecting things to be done for them and this is unfair to expect this of the service. Both Sarah and Felicity refer to the concept of expectation and its role in helping people to understand the responsibility they are undertaking. Felicity also offers a practical solution from the perspective of the service, suggesting that they ought to be realistic and open about what is required of someone who is choosing to access treatment:

> "*I don't know, I don't know whether they need to stress a little bit more that you know, they're here to help, but you need to go away and you need to use the tools yourself. Maybe that could be stressed a little bit more. It's alright coming here, but you've actually got to go and try some of this stuff, without actually making them feel like they're being preached to, you're being preached to, I don't know*" (Felicity, 461-465)

Thus, participants recognise the worth of an IAPT service so long as you are willing to put the work in, although each accept that this attitude may not be shared by everyone.

One final sense of duty and responsibility beyond treatment cessation was taking on a role of advocacy, which involved championing and publicising the service to others. For Michelle, it was about noticing it in her husband, while for Maria, it involved educating and supporting other women in her close family circle. Felicity considered her friends with whom she now recognised similar difficulties in, with Kate similarly recognising them in both her family and friends:

> "*Now it's spreading by word of mouth, and that's important, well hopefully it's to help other people and show people they're not alone, and you can get over it, well not over it but you can like get it under control sort of thing*" (Kate, 372-374)

It appeared to give them great satisfaction in being able to publicise services to others. Equally, it may be due to the fact that service awareness was considered poor, or that the influence of others was beneficial for motivating them (see Navigating the Unknown p.177 & The Role of Others p.206) that these participants had since taken on this role.

6.6 Perception of Self

Participants made sense of their experiences of service engagement by exploring what it meant to them. This process included contemplating whether the service was right for them and whether it matched closely with how they understood their own distress. It appeared that a participant's understanding of themselves and their issues was subject to change, in response to interacting with a service. They also judged their own recovery via a variety of means, either by drawing on internal or external sources of validation.

6.6.1 Finding the Right Fit

Participants explored their experience of service engagement continuously in the context of asking whether the service was right for them. As already highlighted, the stages before service engagement seemed to participants like they were navigating the unknown (see Navigating the Unknown p.177). At each stage, participants appeared to be somewhat tentative, questioning what the service could do for them? And was this right for them? Participants emphasised their journey as being personalised, unique and dynamic, therefore, considering it to be that no two clients ever have the same experience:

> "*I think for someone else they might do something completely different. It is personal, and it is listening and it is understanding, and it is, for them, knowing that they can move you forward, they know what to put in place to help you do it*" (Michelle, 511-514)

The process of finding the right fit was therefore conveyed as being unpredictable, something that could not be resolved up to being engaged in therapy. The flexibility

of sessions was appreciated by participants who sought to explore these questions for themselves.

Various experiences were described by Rachel who spoke of her engagement with multiple services, seemingly taking elements from each, or until she found the one that was right for her:

> "*I've had a lot of experiences with a load of different types of things, to be honest, like CAMHS and others. Maybe that prior experience influenced my expectations, this was different to anything I had done… counselling you just talk about your week, or whatever, like what's been upsetting you, and then with the wellbeing one that was the same but that was in a group. I had hypnosis before, was pretty weird, just made me go in a deep relaxation, I don't know. Yeah this one was different, it was like also learning techniques if you know what I mean*" (Rachel, 273-279)

Cataloguing each intervention, she admits to herself that these may have not worked for her or have failed to continue to work for her. She speaks elsewhere of needing an open mind for approaching these types of things, highlighting her willingness to adapt.

Trevor describes having dabbled in different services over previous years, with him being unable to commit, mostly due to denying the nature of his condition:

> "*I think I'd been a revolving door with this if I'm honest. I've kind of looked at this many times over the last 30 odd years or so. Kind of lifted up the rug and swept it back under there and all that, oh it's okay*" (Trevor, 63-65)

The period Trevor refers to represents a large portion of his life. Referring to himself as a 'revolving door' suggests that he has attempted to access many different services over the course of many years. Unfortunately, it has taken him 30 years to find the right sort of service and he is in fact still searching. Trevor also refers to the concept of denial playing a role in his process of finding the right fit, indicating that he had

not found a service that would enable him to accept himself. Sarah too speaks of denial when describing her decision to move ahead with therapy:

> "*Via the GP, I didn't discuss it with her actually, I'd been to see her and she kept prescribing antibiotics, not antibiotics, antidepressants and she kept prescribing a higher dose, and a higher dose and she said I think you need to go and talk to somebody, and I really wasn't keen to be honest, and I said shall we try a higher dose first? And so, we went higher but in the end I went yes I need to go and talk to somebody really*" (Sarah, 11-15)

For an indeterminate amount of time, Sarah speaks of using medication to mask her distress, increasing to a higher dose, before realising that medication was no longer right for her. Exhausting this option and taking on board the advice of her GP, she accepts that she must try a different course as this one is failing her. Being in the right place for yourself was emphasised by participants and may explain why the process of finding the right fit lasted so long:

> *"I think it's very dependent on who you are speaking to at the time and where they're at. Because you can make suggestions and people might not be at the point where they would actually embrace therapy of any sort. Because you have to recognise that you've got a problem"* (Michelle, 453-456)

Michelle referred to this concept earlier in her interview when discussing her husband: "*I think to be honest with you, he could probably do with using the service as I've done, but he's not at that point at the moment*" (Michelle, 69-70). These points suggest that finding the right fit means being open and accepting of yourself and your problems. Consequently, it perhaps helps a participant understand what they are capable of and willing to commit during a specific period in their life. Sarah contemplates this when recalling her decision to opt for therapy one-to-one instead of in a group:

> "*I think now because I've got more confidence, I wasn't, I'm not as bad as I was, I would do it now, but at that point it wasn't the right thing for me to do.*

> *It certainly wasn't, because I don't think I would have said anything when I first went, no I wouldn't have joined in, I really wouldn't*" (Sarah, 421-423)

Sarah can reflect on this moment, recognising that the different points in time would result in a different outcome regarding her engagement. Having considered the options, she can question and judge what is right for her at that specific moment. She recognises that this is subject to change and therefore, the process of finding the right fit can change with it.

Felicity also recognises the need for a reflective space in finding the right fit:

> "*I've always had careers where I've worked 10, 12, 14 hours a day, I've always been self-employed, well last seven years I've been self-employed so you know you don't have, time to actually think about what's wrong, you just experience what is wrong. And you have to sit through that agony, and think right, let's go on to the next thing and you don't even evaluate what you've done or where you've been. So going to counselling and suddenly someone going, right, tell me what's wrong with you, don't know?! I've never even thought about it. I know I need to be here… So that was quite good because it focuses you and makes you sit down and, you know, you need to go inside your head and find out what is wrong*" (Felicity, 144-152)

Her narrative elaborates on the notion of uncertainty given that she has not had adequate time to reflect on what it is that she needs. The prolonged process of finding the right fit in therapy by engaging with multiple services over the course of many years may refer to the point that participants are unsure of themselves about what is right for them. Hence, they are using a tried and tested method until things eventually do seem right for them. This process appears to require the use of a reflective space for which the service is successful in providing. Having found the right fit, participants appear to feel extremely fortunate in doing so.

6.6.2 How the Service Sees Me: Including Challenges to Identity and the Role of Language

Nearly all participants (excluding Kate) considered how the service judged them or was perceived to judge them. The role of language was important in this regard, with labelling and specific phraseology seized upon when it seemed to challenge their identity. Felicity elaborates on this:

> "*I must admit, on those forms that we fill, and it says patient's name at the top I thought, well I didn't like patients name. I didn't like patients name at all, made me feel like I was clinically ill, and I was in a straightjacket. Yeah, it's just like, I didn't mind the questions, I mean some of the questions were quite hard reaching, some of them were are you going to cause physical harm to yourself, and I appreciate that they've got to ask all those but I thought, whoa this isn't me. But you know you fill it in... But I just think it's just that patients name at the top, it kind of really turned me, I thought am I a patient? I suppose I am really*" (Felicity, 506-512)

The use of the label 'patient' risks discouraging Felicity, who, up until that point, hadn't considered herself to be ill. Her reaction conveys a kind of offence and anxiety about how the service and others may see her. It also strips her of her individuality as she then attempts to distance herself from this label. Disheartened, she is forced to accept this label despite it making her feel uncomfortable and at odds with how she understands her distress. This chimes well with Trevor who, clear from his other comments, is particularly disappointed and thus critical of his IAPT service regarding its approach:

> "*they talk about helping you think differently, and I did think if I was in the depths of despair and depression and somebody told me I wasn't thinking properly, but perhaps I'm being a bit cynical, but you know what I mean? Not only am I depressed, I'm not even thinking properly*" (Trevor, 16-19)

Trevor recognises his pessimistic attitude about the service but for him, his point is clear. He perceives the language used by the service as being condescending and

dangerous. It communicates the message that a participant's experience is less meaningful as you are judged to be not thinking clearly. 'Thinking properly' precedes all other behaviour and activity for Trevor, therefore, to challenge this fundamental component is to challenge his very being. However, Rachel's comments contrast this attitude, as these labels instil a feeling of hope in her that she will someday be "*cured*" (374), highlighting that the impact of this language is relative:

> "*because I don't want to have it forever so I'm seeing it as a mental illness, that I can get rid of... so when I'm better it will be gone*" (Rachel, 380-381)

Participants appeared to feel uncomfortable about confronting their issues and allowing others to see this. This resulted in a problem when considering the use of disorder-specific measures, which directly fed back and forced participants to reflect on their issues:

> "*It just sounds worse on paper, like when you're scoring yourself out of 10 or whatever*" (Rachel, 184-185)

> "*actually having that, that information come back at you from that piece of paper, could be really tough*" (Trevor, 54-55)

These responses imply that the scores on paper can potentially exacerbate issues. It is also a risky exercise as these issues are then public for another person to see. This feeling might be made worse if the scores are not perceived to reflect a participant's experience and understanding of their distress, as demonstrated by Felicity:

> "*my last week, my answers were higher, or worse than I had ever been, but I was a lot better… because the questions were structured in a way that, had you suffered from panic attacks, yes I'd suffered from them, more this week, because I'm stressing about money this week, so it's actually external to something that's actually happening here, but what you've not asked me is how I'm coping with it. I said my sheet will look a lot worse by far, you can look at this and say well actually if anything she's got worse in this counselling, when I hadn't, I had had a lot of stress that week so I had been*

panicking, but I had actually dealt with it a lot better because I was using the techniques I had learnt. But there was nothing on that form that allowed me to say that, nothing at all" (Felicity, 301-310)

Here the scores are not a true reflection of how Felicity is coping with her issues. They leave her feeling restricted, forcing her to approach her therapist about what is going on. She contemplates how the service will see her, feeling guilty that her scores are high despite the fact that she has gained a lot from the service. Notably, she comments and points to the fact that these measures concentrate only on negative aspects and will therefore only provide the service with a limited understanding. Likewise, they are perceived to overlook her strengths and what she has gained. Consequently, this leads her to feel disappointed and discouraged as the recognition about her recovery remains illusory and improperly judged by the service. Nevertheless, as discussed elsewhere (see The Enabled Self: Validating Recovery p.202), these scores can be useful as a source of validation for progression in treatment.

Participants also contemplated how individual practitioners perceived them throughout their engagement. Michelle became anxious about being late to a service as she became unsettled about what they might think:

"*you start to think well, what's everybody else going to think about me, I'm late, I've not made provision for the journey and you pressurise yourself and this is where you start to make yourself ill again*" (Michelle, 109-111)

While Sarah judged a subsequent phone call to mean that she was considered particularly risky because of how upset she had initially been:

"*about two weeks later another gentleman rung me just to confirm the details and run things through again. I think just because I'd been so upset really*" (Sarah, 55-56)

Through the sharing of information, the service was able to allay any doubts about how the service may perceive or judge them wrongly. Sarah discusses the usefulness of sharing and being able to challenge this information:

> "*when I spoke to the gentleman on the phone, everything was written down and then posted it back to me, and said you said this, do you agree with the way it's been documented. And that was good because it's sort of a reminder of what we talked about. So it was quite transparent, and a good way of dealing with it. So I thought that was good really, because of course you can't remember what you said*" (Sarah, 104-108)

Sharing information had the benefit of confirming to Sarah how the service saw her. Without this information she may have been at risk of ruminating and becoming anxious about what she had revealed, this being particularly important as she had a tendency to forget. Moreover, sharing this information also seemed to provide a reinforcing function, thus keeping participants engaged. Being equipped with this knowledge puts her at ease to open up more, confident in the fact that she would always know where she stood with the service.

6.6.3 The Enabled Self: Validating Recovery

All participants (excluding Trevor) emphasised feeling more enabled and in control. In particular, it was felt that the change in themselves was substantial:

> "*Most satisfying thing is that it's enabling, that's my word, that's my buzzword, it's enabled me to move on in my life"* (Michelle, 493-495)

This change was discussed either in the context of service engagement, going from session-to-session, or as a sharp contrast between times, as in before and after their time with a service. For them, the change was undeniable, evoking feelings of awe and wonder. Sarah describes it as: "*I can see a big change, a massive change*" (Sarah, 151) while Kate similarly refers to it as: "*absolute transformation, for me it really did help me a lot, and I hope it really did help everybody else like it has me*" (Kate, 282-283). Felicity also supports this notion, feeling shocked by what the

service had done for her: "*I was just so surprised that it worked and it just went away, and I just thought wow this is great*" (Felicity, 348-349). These responses suggest that the time spent with the service not only met their expectations but surpassed them. It may also be that they are surprised by their ability regarding treatment engagement.

The source of this change in self was represented as a contradiction. Participants tended to refer to a gradual change during their time in treatment as described by Maria:

> "*it was definitely better coming here. Noticing a change, slowly, slowly, week after week, better, better, gradual*" (Maria, 58-59)

However, participants were often unsure of the specific moment that they realised this change had occurred:

> "*I just noticed a change in myself that I'd become more positive and my husband had noticed as well*" (Sarah, 247-248)

It suggests that the process of becoming more enabled is not linear but dynamic, with its attainment difficult to ascertain. Therefore, it seemed necessary for participants to refer to other sources of information to confirm that they were, in fact, now more enabled. Notably, Michelle's time with a service was referred to as reclaiming control, something in her she felt was lost long ago:

> "*it gave me control, which is what she was aiming at getting me to do, take the control back, something that probably, I've not been able to do throughout my life because of various circumstances in younger days, so I felt she was allowing me to take control*" (Michelle, 194-197)

Michelle uses both an internal and external source as a means of validation. By taking control, she can prove to herself and her therapist that this change in her has taken place. This process seemingly took time with participants in the early stages more likely to relinquish control to their therapist, possibly as a result of their

uncertainty (see Feeling a Connection in Therapy p.186). However, as treatment continued participants increasingly felt more able to take control and validate their recovery in doing so.

Sarah too accepts the change in herself, identifying a contrast in her behaviour and agency:

> "*I knew I was getting a lot better because I was looking for things to do, whereas all summer I was looking for things not to do*" (Sarah, 192-193)

Additionally, participants sought to find evidence that the change in themselves could be validated, as described by Michelle:

> "*I knew in myself but it was good actually to tick all the boxes and go through it with the counsellor accordingly because that was an acknowledgement that it wasn't just me thinking it, it was her saying yeah, well done, you've got there. Yeah so it's nice to have that, that little bit of acknowledgement from somebody else, that you're not kidding yourself*" (Michelle, 373-376)

It also appears here that the use of treatment scores was helpful in reducing any self-doubt regarding her recovery. Likewise, it is equally important that her therapist recognises this change, something that is made easier using treatment scores or to 'tick all the boxes'.

Similarly, the change in treatment scores also provided a therapeutic benefit to participants as they could visualise their progress, either from session-to-session:

> "*I: Yes, they used to go through it almost every week and they could see the difference every week, my points started from 12 and they started going down, down, now they're down to 3 or 4.*
>
> *R: And was that good to see that visually?*

I: Everything I could see at the starting, it was all full but as I was improving, it made me feel more better" (Maria, 121-127)

Or when comparing the first session with their last:

"*when I went to go and see the therapist I filled one in and it was on the first week and the score was very high, and then on the 6th time that I went to see her because I said I feel so much better, you've given my life back to me, and I think that she has honestly given my life back to me, we went through it and it was like nil. I was absolutely amazed*" (Sarah, 188-192)

So, not only were the use of treatment scores helpful for validating their recovery to others, but they also acted as a source of validation for themselves. Maria directly links these scores with identifying a positive change in her, almost as though her change was reinforced. Sarah mentions ahead of seeing these scores that she had already recognised a huge change in herself, yet the actual act of seeing these scores created a subsequent emotive response in her. Sarah's description of seeing these scores were experienced almost as though her issues had left the page, or even the room, further reinforcing her recovery. Kate refers to the value of seeing the change in scores either by session-by-session or when comparing her first and last scores:

"*To start off with I did get very high numbers, only because I was very low in myself. The last one was my best one, which did boost my confidence, because I'd done it all on my own, and I felt a thousand times better for doing that, to see it, because I also did it for my own future reference that's why I did the thing, to see how I'd progressed each week*" (Kate, 196-199)

Kate links her personal accomplishment with a certification that her scores had changed. It appears that referring to these scores represents a process of encouragement during treatment, reinforcing a participant's ongoing progress. Moreover, it carries the benefit of validating an overall change from beginning to the end of treatment. Felicity, who earlier raised concern about the scores not reflecting how she understood her distress (see How the Service Sees Me: Including Challenges to Identity and the Role of Language p.198) commented:

> *"I think if you show people graphs and progress they will come again, maybe people do need to be encouraged to be, to say you've done brilliant from this week to last week and I don't know. So there are flipsides to them"* (Felicity, 358-360)

Therefore, it appears that when scores do work they can be very powerful in keeping participants engaged or validating the change in themselves. However, as Felicity recognises, this is not clear cut and there will likely be different responses to them, just as she had experienced.

6.7 Outside Factors

This theme examines the influence of outside factors on the experiences of participants during their engagement. It describes how other individuals in a participant's life may encourage or discourage their engagement, or possibly even move to recovery. On top of this, it was clear that the rate of access and relative location of a service was important, with the journey itself representing an achievement, possibly even possessing some therapeutic utility.

6.7.1 The Role of Others

The influence of others featured prominently in participant narrative, particularly regarding their decision to access treatment or act as a valuable source of encouragement throughout their ongoing engagement. However, there is a range of responses regarding the role of others in encouraging a participant's access and engagement. Michelle talks about her husband and her relationship with him playing a pivotal role when realising she required treatment:

> "*I mean, it was my husband who told me that our marriage wasn't working, and that was such a light bulb moment that I thought, yeah, well I'll go and get myself sorted out. To be honest… I think he could probably handle some help himself, but we're not there yet so...*" (Michelle, 456-460)

The experience that Michelle alludes to as being a 'light bulb moment' suggests that she was either blind to her distress or in denial. Her choice of words conveys a stark and uncomfortable realisation. She tentatively teases at the fact that her husband could also benefit from some form of intervention, this being characteristic of the way that she often refers to him throughout her interview. It communicates the message that Michelle is disappointed in the fact that she has been accepting of her issues, whereas her husband hasn't. She eagerly accepts his judgment and sets about the steps necessary to attempt to fix something that she perceives is wrong with her, even though she also considers something to be potentially wrong with him. Although the role of others has seemingly encouraged her to access treatment, the implicit assumption regarding the issue being solely hers may invoke feelings of resentment and tension, thus impacting on Michelle's time spent with a service.

Feeling guilty for her impact on others, Kate dwelled upon the relationship with her children and the impact her issues have had on their lives. Here she describes her anxiety regarding birds:

> "*I'd loved to get over the fear of it, because like obviously with wanting to take my son to the park and things like that and he misses out, and it's not his fault it's mine*" (Kate, 81-83)

By doing this for her son Kate can draw upon a huge sense of purpose which ultimately boosts her motivation and acceptance of therapy. Throughout her interview, Kate was particularly optimistic that this was a very real possibility, having gained a lot from her time in treatment. Accordingly, this highlights a crucial and dynamic link made between the service and the role of others, with each influencing the other. Looking at the data, it seems that the role of others can play an important role in a participant's openness and acceptance of therapy. Trevor, for example, had previously had a difficult experience with another counselling service, leading him to be cautious about how he engaged with subsequent therapists:

> "*I've had a difficult, I've had an experience with a counsellor face-to-face, which I thought was a great relationship. And then after the event it transpired, our paths crossed again in, and actually, yeah not in a good way.*

I was borderline making a complaint, on the private counselling, and that kind of knocks down your faith, your trust in services" (Trevor, 133-136)

Due to his experience and the role of this one individual, Trevor finds it hard to place trust in therapists working within this field. Remembering the prolonged nature of Trevor's experience in finding the right fit for him, this may go some way to explaining why it has been difficult for him to commit, earlier identifying himself as a "*revolving door*" (Trevor, 60). Felicity exemplifies a more positive instance in which the role of others can enhance a participants' openness and acceptance of therapy. Drawing on the recommendations of others as a source of motivation, it appears that her judgment about the service was already positive in advance of her engagement:

"*I've had a friend who had also had counselling, who is also self-employed, a lot of self-employed into counselling you know, it's all those hours alone, it's all those money worries, and stuff. But I'd had a friend who had had counselling who sort of lives in … and said it was the best thing he ever did and he said go to your doctor and ask for it, because we chat a lot, as you do, when you're self-employed, we're all each others' friends, so he kind of prompted it, and he was very positive*" (Felicity, 106-111)

Given the fact this person is someone in similar circumstances, Felicity is more enabled to self-identify with how counselling might be good for her. The positivity she draws from this friend gave her the courage and confidence to be able to approach her GP about this. Notably, this is important as Felicity mentions elsewhere her having to plead with her GP about being referred (see Navigating the Unknown p.177). Similarly, the recommendations of others are likely helpful regarding accessing a service and may explain the advocacy role certain participants had taken on since leaving the service (see Sense of Duty and Responsibility p.191). It seems that without the recommendation and encouragement of others, participants may not have been able to make it beyond the initial barriers to a service. Consequently, this may prove problematic as certain participants spoke about wanting to keep things quiet, seemingly in denial about their issues and hiding it from others. Sarah, in particular, wanted to remain anonymous during the early stages of her engagement,

highlighting that she might also be hiding her issues from others. However, the attachment to her family did stop her from wanting to attempt suicide:

> *"Yes, definitely because I sort of didn't want to be here at that time, I kept thinking oh I wasn't going to kill myself because of what it had done to me watching my husband do that… I couldn't do that to my children, even though they're grown up because I knew they'd have to live with that. But I just didn't want to be here, if I had been run over I would have been quite happy, but you know I couldn't actually kill myself because of what it would do to my children, knowing the effect it has had on my life"* (Sarah, 352-357)

This extract again portrays the role of others, in this case, the family, as playing an important role in the management of a participant's issues. Sarah's attachment to her children and feelings of guilt provide her with a lifeline that keeps her resilient. Her personal experience and upset about her husband's actions on this matter gives her enough of an emotive response not to go ahead with this action. Sarah later draws upon the feedback of others in her family as source of validation:

> "*I just noticed a change in myself that I'd become more positive and my husband had noticed as well. Because I had actually stopped talking in the family*" (Sarah, 245-248)

For Maria, her therapist was successful in reminding her of the role of others and her attachment to them:

> "*She was nice, the thing is she guided me, and for me good things, positive side, like dress up, stay fresh and you've got your children, you need to look after them, she says, were really helpful. Good talking to me*" (Maria, 303-305)

And similar to Sarah, Maria also uses her family to help validate her recovery:

> "*Most positive side, is that I'm better, I was unable to look after my family, my children and at home everything was so upside down and I'm so happy, that I'm able to do all those things*" (Maria, 232-234)

These responses support the idea that service engagement is not a solitary or individual endeavour but is shared across multiple people. These individuals can be either a source of guilt and tension or they can be a source of encouragement, motivation and validation. From a service perspective, it seemed useful to participants that practitioners be mindful of this.

6.7.2 The Necessary Journey

All participants focused on the process of accessibility and its role regarding service engagement. Accessibility was described along two main components: speed and location. It was widely accepted that quicker access would be associated with greater levels of engagement, as referred to by Sarah:

> "*I: I think just the support really and I didn't wait that long to see my therapist afterwards because I was referred about three weeks, which isn't that long... So it wasn't that long, and I've had a real positive experience from it all really.*
>
> *R: How do you think it would have been if you had waited longer?*
>
> *I: No I would have probably thought oh I don't really need this. Because it would have been too long between it, the instant access is definitely important, yeah it's good"* (Sarah, 334-341)

Waiting longer for treatment appears to create more opportunity for Sarah to ruminate, leading her to doubt herself and her decisions. Similarly, more immediate access is conceived as countering her feelings of denial and uncertainty. Therefore, the instant access conveys an endorsement that she is entitled to treatment and that

her suffering has meant something. It also expresses a concern from the service invoking feelings of value. Michelle elaborates on how the instant access to a service communicates this value:

> "*It was very quick, I should only think it was under a month actually. I was warned it could take 6-7 weeks and it was a lot quicker than that. In fact, all the referrals I've had have been very quick. And yeah that's important, needed to get on with it, once you've made the decision that, and recognised you need help then there's no point in sitting back and waiting, you need to get on with it and get started, chances are you might think oh well, they're not bothered, I won't bother, its back to square one*" (Michelle, 81-86)

It is perceived that the longer she waits to access a service, the less interested and therefore, caring the service will be. Michelle is in agreement with Sarah about the need for instant access and they both appear surprised with how quick access was in reality. This contrasts Trevor's experience who had waited far longer than Michelle and Sarah:

> "*I mean I've already done the 14-week wait and I'm still apparently another 12 weeks, ten weeks away... part of me thinks well why can't there be a parallel process where actually you do an assessment with your GP*" (Trevor, 177-181)

Trevor's prolonged wait had the consequence of leaving him feeling out-of-touch, his time wasted and possibly disregarded. The urgency in participants to get things underway suggests that their level of motivation is potentially a fleeting experience, sustained only by being resilient. In Michelle's extract above, she uses imagery of being physically sat still to describe how the period of waiting to access a service feels. Participants had a tendency to refer to both a real and metaphorical journey when describing their experience of recovery and service engagement. It is possible that the actual journey into a service is reflective of, and influential in, their move to recovery.

It did, in fact, appear as though the journey itself could be considered an achievement although there was a risk and somewhat of a paradox if this turned out to be stressful. Rachel elaborates on this point:

> "*Well yeah, and I don't like driving when I don't know where I'm going so that makes me panic as well so, I thought it seems a bit contradictory if I'm getting stressed and all panicked to go somewhere to tell me not be stressed and panicky. So the journey could have been quite stressful also*" (Rachel, 119-122)

Linking the stress of the journey and the topic of her issues, Rachel quickly recognises the pointlessness of her engagement should the journey cancel out all the good that therapy provides. It also risks the therapist potentially being patronising if the journey to get to the service is difficult. This chimes well with Michelle's account that speaks of the importance and relief for local access:

> "*I was a little bit concerned to begin with, you know that I might be sent to miles out of my area, in an area I know nothing about really, that would have increased the stress. Again it was a real relief to find out it was on the doorstep, you know that makes a big difference... You're trying to deal with a lot and you can't add that on, at the time, later on you can but at the beginning it's difficult, so yeah, much relief. If you haven't got any pressure on you for anything else then that's fine you can just sit back and enjoy the journey*" (Michelle, 102-108)

There is an expectation in Michelle who refers to an anxiety about the service being at a distance. Similar to Rachel, she likens the stress of the journey as being unhelpful given all that is being confronted in treatment. The service is successful in providing local access and putting her concerns at ease. Felicity also refers to a feeling of relief and being impressed by the location of the service: "*Location is perfect for me, I could literally walk there, it's 5 minutes from me*" (Felicity, 65). Michelle refers here and elsewhere in her interview about the journey having become easier. This development provides instant feedback to her that treatment is working as she can cope with the journey more tolerably. She classifies overcoming obstacles

in the journey as "*those little victories*" (Michelle, 55) supporting the idea that the journey of accessing the service was an achievement. However, the value in local access expressed by these participants indicates that this journey must not be too strenuous so as to discourage engagement.

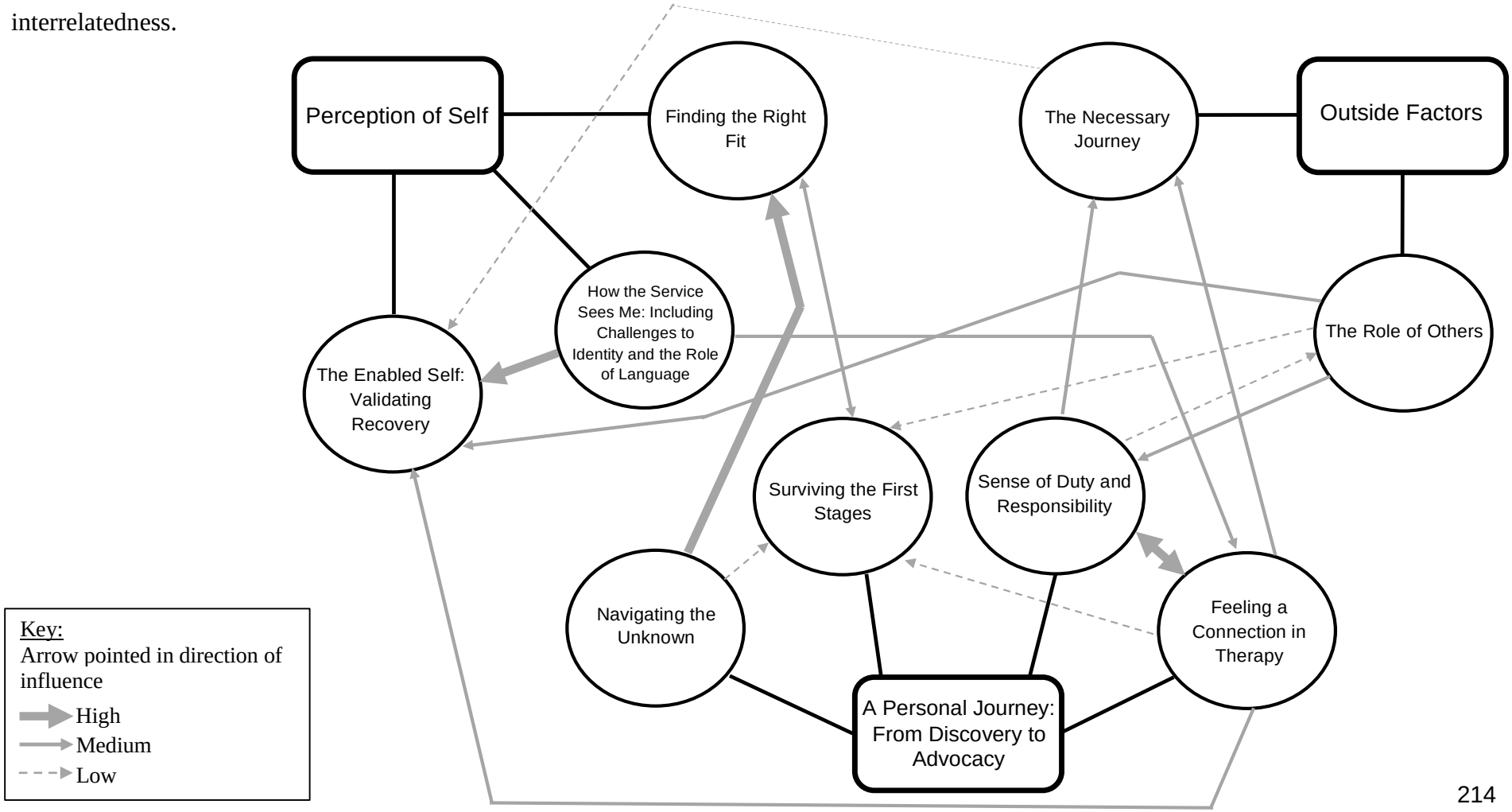
It should be noted that making the journey into a service was influenced by the fact that participants preferred a face-to-face format for their therapy (see Feeling a Connection in Therapy p.186). It seemed that reflecting on the journey into a service was also indicative of something else; this being what the service then came to represent. Sarah, in particular, refers to the service as a kind of safe space away from a stressful home environment:

> "*it was always face-to-face, and when I was doing that yes I thought it was, it was easier to talk to someone, and I think because it was away from my house as well, like a neutral sort of area really. Like if she would have come to my house I wouldn't have liked it really*" (Sarah, 178-180)

Therefore, the distance between the service and her home is useful for Sarah as she is able to distance the main source of her stress from that of her recovery. Given that the service represents a neutral space, the expression of emotions is not subject to extremes and is thus easier to manage. Maria similarly suggests that her home environment is not a space that is constructive to the format of therapy: "*if I was sitting at home, I could have got more worser*" (Maria, 276-277). It appears that the actual act of moving out of the home to access treatment is beneficial therapeutically. Therefore, it is useful that the journey into a service is quick, accessible and within reach to enhance the therapeutic value of making this trip.

Figure 8: Clients Engaging with Services: Diagrammatic Gestalt of the Themes and their Interconnectedness

Given the interconnectedness of the themes, I have compiled a diagram about how each subtheme is related to one another by way of influence and the strength of that influence. This technique, I hope, will aid in the comprehensibility of the findings by illustrating the subthemes' interrelatedness.




Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

7 Discussion

7.1 Overview

In this chapter, I present and discuss the findings of the study in the context of the available literature. For the sake of clarity and rigour, the chapter will refer to those participants who were delivering and implementing services using the term ‘practitioner’, while referring to those engaging with services as ‘client’. This terminology distinguishes each group, thus making it easier for comprehension. Given that each of the themes were strongly interrelated, each master theme and its subsidiaries has been amalgamated under a series of new headings, incorporating other literature to help guide the reader throughout this chapter and line of thought. Finally, the chapter will round off by discussing the methodological limitations that may have a bearing on these findings and overall conclusion of the thesis.

7.2 Findings Summary

The findings revealed a varied and diverse range of experiences among both groups. For those implementing services, the process was described as a genuine opportunity to make a real change in the provision of mental healthcare. The Improving Access to Psychological Therapies (IAPT) delivery model and ensuing commitment from central government meant that provision was clearer and less chaotic, sparking feelings of assuredness, pride and relief. Throughout the process of implementation, practitioners attempted to modify their service in light of contextual influences so as to become more integrated, responsive and locally relevant. It was characterised by a series of relational and collaborative processes, both within and between service settings, negotiating multiple, and at times, conflicting pressures. Moreover, there were many challenges reported about treating clients who do not fit the model, leading to concerns about gaps in care and an impact on service effectiveness. Overall, the experience of implementing the IAPT delivery model appeared to be a constantly shifting but rewarding process.

For those engaging with services, the process was highly context dependent, revealing a change in dynamics between the service and themselves. Notably, the initial stages were characterised by a heightened level of uncertainty and apprehensiveness, although this was soon resolved during the early stages of engagement. Accessing a service represented various barriers to overcome, with many experiencing high levels of confusion and anxiety in the intermediary stages. These feelings were further compounded by a shared lack of awareness for services, which ultimately led to clients publicising and advocating on its behalf post-treatment. In their experiences leading up to and including their first contact with a service, behaviour was characterised by a process of finding the right fit and continuously judging what it meant for them. Therapeutic rapport and feeling a connection in therapy was central to ongoing engagement, emphasising the need for direct human contact. Interestingly, some of the biggest impacts on service engagement were beyond the control of the service, including the influence of others, particularly that of the family. As a whole, the nature of provision offered some merit in supporting client empowerment and responsibility over their engagement.

Across both groups, there was a shared understanding that the initial stages of service engagement were critical and required greater attention. A lack of communication during prolonged waits was considered to be an issue, leaving clients feeling confused and isolated. Both groups described how the use of Routine Outcome Monitoring (ROM) is useful in boosting and justifying ongoing engagement. However, these scores may not necessarily reflect reality, being at odds with how a client understands their own distress and move to recovery. Equally, both groups recognised the value of preserving the therapeutic relationship, although the current emphasis on self-reliance, client autonomy and quick, high-volume throughput made this difficult. Generally speaking, the varied nature of experiences from participants revealed that the implementation of services represents a reactive, responsive and adaptable process, which seeks to celebrate service innovation through reflexive monitoring and client feedback.

7.2.1 Considering the Representativeness of the Findings

The findings presented here make no claim for generalisability, having emerged from two small, homogeneous samples about their subjective experiences, together with my interpretation of them. Certainly, my own subjectivity and research interests will have inevitably influenced the interpretation of these findings (Blaikie, 2007) as will the selectiveness of the sample included. However, steps were taken to limit the impact of this by as much as possible, such as following a clear and robust methodological framework (see Methodology - Data Analysis p.107). Therefore, I invite and remind the reader to judge these findings and the subsequent discussion by their limited applicability and representativeness, while appreciating the rich, in-depth nature of the experiential evidence, for understanding the implementation and operation of services.

7.2.2 Discussing and Conceptualising the Themes

To conceptualise the themes and their interdependency, it is useful to frame these findings in line with existing theory about the implementation process. Drawing on these frameworks will aid in the comprehension of findings, including their relationship to one another, as well as to the existing literature. Drawing on the core constructs of the Normalisation Process Theory (NPT), this chapter discusses the principal findings around cognitive participation and collective action (relational and operational work), coherence (sense-making work), and reflexive monitoring (appraisal work) (May et al., 2010). Using these concepts provides a well-rounded overview of the implementation process, with each conceptualising different aspects in unique ways to provide the reader with a greater overview of the findings.

Although the inductive nature of Interpretative Phenomenological Analysis (IPA) means that no former attempt to theorise about these concepts was possible, beyond the formulation and structure of the questions in the interview that is, the frameworks used here tie in closely with the responses and central experiences conveyed by all participants. Moreover, the use of IPA can lead to the discovery of new and unexpected findings during data collection and analysis (Smith et al., 2013). Therefore, the use of these frameworks, in addition to the advantageous, exploratory

nature of IPA, afforded me a sound basis from which to discuss and interpret the findings. The themes have each been used to guide the discussion under new headings, helping to conceptualise the findings in light of other related and emerging literature.

7.3 Context Data

When looking at the open-access data in connection with participant responses, it was possible to interpret, to some extent, how local area context may influence implementing the IAPT delivery model. It is important to remember that no direct relationship can be drawn between these figures and the experiences of participants; however, they are helpful for contextualising the qualitative findings and service provision. Recruiting services via a single Foundation Trust (FT) was also useful for comparing services in this way.

All practitioners made it known that local socio-demographics had a direct impact on their decision-making during implementation. These findings are in keeping with other evidence that also found contextual influences greatly impact on the implementation of the delivery model (Byng et al., 2011; Glover et al., 2010; Richards et al., 2012). This, in turn, created a variation in service area priorities resulting from the divergence in context and individual attitudes. For Isabelle, it was important to have an eclectic mix of treatments to cater for multiple client needs, whereas for Melissa, getting referrals under control was of primary importance as the service had inherited a large waiting list. This affected the role of the assessment session, which was presently being used for therapeutic delivery. Melissa's service represented the largest overall and had the highest rate of referrals entering regarding access (83.5% of referrals entering the service within 28-days). Conversely, Daniel's workforce had a greater proportion of high-intensity therapists, meaning that the assessment session could be overseen by more experienced staff to support the Psychological Wellbeing Practitioners (PWPs), but not all services were able to implement this. These situations reveal the reactive and iterative processes involved during implementation, influencing the delivery model against implementing a more ideal form of provision.

Across all services, reaching the 15% access rate target by the March 2015 deadline was placing great strain on participant experiences, possibly accounting for a greater emphasis on the development of low-intensity interventions (see Increasing Provision by Incorporating More Low-Intensity Treatments p.222). The role of self-referral differed between areas as some services referred to it as managed self-referral, maintaining the gatekeeping role of the General Practitioner (GP), while others implemented a complete self-referral pathway, in the interests of boosting access and meeting targets. The implementation of a self-referral pathway also influenced the decision to include a follow-up procedure, with some services instead speaking of using self-referral as the follow-up. These illustrate the pressures and tensions on services to boost access in light of targets, sometimes at a cost of their relationship with GPs. Accordingly, these themes will be discussed in the subsequent sections.

For all participants, the concept of recovery as a result of crossing a clinical cut-off score was not judged to be entirely useful. Responses highlighted that it was difficult to cross the clinical cut-off level for cases presenting with high initial treatment scores, a view that has been recognised elsewhere (Clark, 2014; Glover et al., 2010; Griffiths & Griffiths, 2015). The scores relating to reliable improvement increased the overall rate for services, linking in with the practitioners' comments about using other measures for recovery, such as the client narrative. In short, these behaviours underscore the tensions in practitioners about constructing service effectiveness, something the current system is limited in communicating.

7.4 Cognitive Participation and Collective Action: Relational and Operational Work

7.4.1 Adjusting to Change

It was clear from the findings that implementing the IAPT delivery model represented a huge shift in the approach towards service provision. For practitioners in particular, the task had become more about quantity, driven by a need to increase throughput. Incorporating a high-volume, fast access way of working represented a challenge for practitioners, who increasingly had to adapt their service according to

this change in pressure. Given the unprecedented level of funding it has provided, this likely reflects the ambitions of central government seeking a return-on-investment (Department of Health (DH), 2011a). Understandably, it is usually accepted that the setting of targets is necessary to improve service provision (McHugh & Barlow, 2010; DH, 2011a). Although this may be true, the basis for these targets is predicated on the original economic rationalism laid out by Layard et al. (2007). While this was pivotal in acquiring investment (Seward & Clark, 2010), it highlights a potentially shrewd business acumen about emphasising quantity, possibly over quality. It also likely explains the implicit necessity to stick to treatment guidelines by controlling which clients enter a service so as to boost fidelity and ensure that resource isn't wasted (McHugh & Barlow, 2010; Layard et al., 2006). The implications of this concept are discussed elsewhere (see Protecting and Enhancing the IAPT Programme by Assuming a Classification Certainty p.232) but for now I will return to the impact of high-volume working.

7.4.2 A Target-Driven Practice Emphasising Quantity and Throughput

The recognition and commitment from the government were well received by practitioners, showing great admiration, positivity and gratitude about being part of something worthwhile and unprecedented. Steel et al. (2015) found similar findings, referring to this concept as feeling high levels of personal accomplishment. For the most part, this was likely due to the provision that had preceded the IAPT programme's inception, characterised by long waiting lists and stressful practice (McManus et al., 2009; Mind, 2010, 2014). However, this potentially runs the risk of being complicit, overlooking limitations and making admissions for the current demands placed on services. This pattern could be identified in the experience of practitioners who considered the level of bureaucracy and administrative duties to be at risk of obscuring the principal task in delivering care. Although participants were the first to recognise the limitations associated with the current emphasis on descriptively optimistic targets, they perceived it as a necessity to ensure their service's survival. It potentially highlights feelings of apathy in practitioners about not being able to challenge the pressures on them. Using a case-study example, Rizq (2012a) highlights how the bureaucratic, target-driven culture of the IAPT programme, implemented as a means to attract continued funding from central

government, creates a perverse defence mechanism. Instead of recognising that the task in services is becoming increasingly uncaring and more about throughput, actions are justified in the interests of securing ongoing investment. Here it may be due to fearing that provision might return to the old chaotic ways of working. Consequently, this was apparent in the narratives of practitioners who continually struggled to balance the needs of the many with the needs of the few.

Certain practitioners attempted to test the commitment of incoming clients or were more willing to discharge those who were judged to be uncommitted, justifying their approach by referring to the countless others waiting. This attitude again characterises the perception of clients as a utility for the service (Rizq, 2012a), seemingly being the result of an emphasis on increasingly large targets. However, it is likely that there is an element of pragmatism in this approach, either in respect of budgetary constraints or recognising that for certain types of clients, the timing was not right. The latter point corroborates with the narratives of the client group who seemingly spent much of their time navigating services being in denial, uncertain or reluctant to commit, likely explaining practitioners' behaviour in being tentative to avoid coercing or pressurising incoming clients (Hamilton et al., 2011; Khan et al., 2007; Westra et al., 2010). All things considered, it does highlight a potential avenue for a disconnect between practitioners and clients, as the former may grow increasingly impatient or even resentful (Rizq, 2012a). This is not to say that practitioners included here felt or acted this way, in fact, it was quite the contrary. To give an illustration, Daniel was resistant to any eventuality that could conceivably transform his service into becoming a "sausage machine" (Line 343); something that was considered likely if he remained committed to the bureaucratic and target-driven approaches espoused by the IAPT programme. With this in mind, it appears that practitioners are attempting to resist these types of pressures as best they can to preserve certain aspects of their practice, such as compassionate care.

7.4.3 Increasing Provision by Incorporating More Low-Intensity Treatment

The over-arching pressures on IAPT services which emphasise the treatment of large numbers has led to a high-volume, fast access and low contact style provision. In the

pursuit of access rate targets, there was profound pressure on services to boost low-intensity provision and implement self-referral pathways. The business ideology was at times difficult to accommodate for, with certain practices implemented more as a response to top-down pressures, rather than necessarily in the interests of clients. This ideology forced practitioners to adapt, sometimes against their own clinical judgment, instead basing decisions on functional gains to keep up with these pressures. Indeed, evidence reports that over time, the provision of IAPT services tends to emphasise a greater proportion of low-intensity based treatments (Byng et al., 2011; Clark et al., 2009; Glover et al., 2010; Sharp et al., 2014), with practitioners included here also reporting on these trends. That said, the use of treatment scores allowed practitioners to justify their approach, commenting that recovery rates were left unaffected (see Reflective Practice during Implementation p.245). As a matter of fact, certain approaches required practitioners challenging their own preconceptions about how to organise a service; the most prominent instance being organising treatment delivery akin to a 'call centre' which, although initially resisted by practitioners, turned out to be an effective way of delivering treatment.

It is necessary to recognise that there is ample evidence supporting the use of low-intensity based interventions (Bennett-Levy et al., 2010; Bower et al., 2013; Hammond et al., 2012; Kenwright, 2008; Mansell, 2007; McHugh et al., 2014; Papworth et al., 2013; Stiles et al., 2006, 2008). Equally, the National Institute for Health and Care Excellence (NICE) guidance recommends their use for treating mild-to-moderate Common Mental Health Problems (CMHPs) (NICE, 2011a). Moreover, they may be useful for relapse prevention given their self-management style (Bennett-Levy et al., 2010; IAPT, 2011a), although direct evidence for this remains limited (Rodgers et al., 2012). Additionally, it has been linked with relieving pressures on the workforce and waiting times of other therapists (Chan & Adams, 2014; Clark et al., 2009; Hammond et al., 2012). Fittingly, practitioners made use of them as a means to derive maximum benefit from finite resources. Notwithstanding, there are some concerns regarding the growing emphasis on implementing a greater proportion of low-intensity treatments.

Notably, Barrett (2009) refers to the IAPT programme and its emphasis on high-volume, fast access throughput as the "industrialisation of psychological therapies" (p.132). Certainly, the decision to implement a greater proportion of low-intensity provision was influenced by a need to boost access in the light of target-driven practice. Consequently, the added emphasis on quicker throughput risks minimising discourse, denying adequate exploration of a client's issues (Rizq, 2011). It also risks reducing the voice and narrative of the client in favour of service efficiency and provider gains (Williams, 2015). What's more, client complexity may not always be identified early on (see Predicting Complexity While Increasing Throughput p.236), an issue which is further enhanced by the reportedly low rates of stepping up within services (Delgadillo et al., 2013; Glover et al., 2010; Richards et al., 2012; Radhakrishnan et al., 2013). Similarly, evidence reports a potential concern regarding the dosage of therapy being below that which is recommended (Health and Social Care Information Centre (HSCIC), 2014a, 2014b; Royal College of Psychiatrists (RCP), 2013). It could be that by emphasising a greater throughput, this leads to certain individuals engaging with unsuitable treatments, perhaps explaining client dropout and lower recovery rates (Cairns, 2014; Di Bona et al., 2014; Glover et al., 2010; HSCIC, 2014a, 2014b; Richards & Borglin, 2011). Accordingly, Chan and Adams (2014) found no differences in baseline treatment scores for those entering at either low or high-intensity steps, suggesting that severe and complex cases could be entering the low-intensity stage. Nevertheless, this should be interpreted with caution as their evidence is limited to one service and the use of narrow treatment measures.

On balance, the lower than recommended dosage of therapy suggests that the programme is achieving its aims by using fewer sessions overall, contrasting that which was proposed originally (Layard et al., 2007) and is recommended in treatment guidance (NICE, 2009a). Furthermore, these interventions are relatively new and varied, with limited evidence available about whether their usage can produce sustainable outcomes (Linde et al., 2015; Rodgers et al., 2012). Shepherd and Rosario (2008) argue that assuming low-intensity practitioners will be able to deal with the many complexities of mental health is naïve and unrealistic. Overall, while service efficiency and the enforcement of targets are important, it is equally important not to push for quick wins that are short sighted. That is to say, evolving

pressures should first be mindful of prioritising a business ideology over quality of care, and not emphasise low-intensity provision for the sake of functional and operational gains.

7.4.4 The Urgency in Early Implementation

Instances of unrealistic expectations were particularly noticeable during the early stages of the programme's dissemination and implementation. Given a service's pre-existing context and due to a perceived ignorance from top-down pressures about how long integrating this would take, these stages were particularly demanding. This resonates with comments made by Cooper (2009) among others (Barrett, 2009; Scanlon & Adlam, 2010, 2013; Walker, 2012), who argue that the initial rollout of services was hurried, with ongoing efforts failing to consider emerging evidence adequately enough. Therefore, the urgency to implement services without taking account of the integration process appears to have been an oversight. Indeed, practitioners longed for a preparatory or reflective platform so as to organise their service, although each respectfully accepted that this was not necessarily feasible. Some academics argue that this urgency was the result of a political imperative rather than a scientific one (Cooper, 2009; Scanlon & Adlam, 2013; Walker, 2012). Again, it may be due to the long-standing demands on services (McManus et al., 2009; Mind, 2010, 2014) that ultimately culminated in a hurried dissemination. A consequence of this was that the expectations placed on services during the early stages had a lasting impact, with ongoing progress delayed as a result. Equally, it may reflect changes in the original argument from Layard et al. (2006) who originally proposed training 10,000 newly qualified therapists, only for this to reduce to 3,600 and targets remain the same (Cooper, 2009). Incorporating this newly trained workforce appeared to take a lot of time, with each new member requiring a substantial amount of on-the-job experience (Shepherd & Rossario, 2008), together with a need to be integrated into a pre-existing service context (Lewis, 2012). Consequently, this highlights a further concern regarding the initial expectations placed on services, which potentially overlooks this aspect of implementation. Any subsequent changes in the demands of IAPT services would likely benefit from a more robust consideration of these factors. Essentially, it revolves around the prioritisation of goals. While the number of people needlessly suffering from a

CMHP represents a compelling reason to increase volume throughput, it is crucial that the approach does not lose sight of providing compassionate and effective care. To put it another way, the programme should not favour maximising outcomes without consideration for the process.

7.4.5 Transforming Organisational Culture

The NPT helps to conceptualise how new innovations can be 'normalised' under routine conditions (May & Finch, 2009). As can be seen, implementing an innovation requires that practitioners integrate and make use of an existing workforce. This aspect was portrayed as though the old service, including its artefacts, had been inherited, thus influencing its ongoing operation. In particular, this centred on the impact of existing waiting lists and staff expertise. In keeping with other evidence, this was difficult early on, due to a perceived unpopularity during the initial rollout of IAPT services, as was incorporating those who might be identified as 'non-IAPT' therapists (Altson et al., 2015; Lewis, 2012). In some cases, transforming service provision required extensive relational work and negotiation so as to facilitate these shifts, similar to trends reported by Lewis (2012).

Practitioner attitude and behaviour can impact on the rate and product of implementation (Nilsen, 2015). In the accounts presented here, arranging and negotiating the changes necessary in practice required that practitioners engage with the workforce, to communicate the benefit of certain approaches regarding therapist and client engagement. The NPT defines this as legitimation work, ensuring that those involved believe it is right for them and that they are capable of making a valid contribution (May & Finch, 2009). It also resonates with the personal experiences of those interviewed who expressed feeling part of something bigger and greater than themselves. These points support the need for services to implement a platform for more open and critical dialogue, inviting clinicians to engage in the operational development of the service. Nonetheless, Haarhoff et al. (2015) found that, despite the value of a reflective space among IAPT practitioners, many felt this was unfeasible due to a lack of time and urgency of provision within services. Then again, enabling this platform might help to overcome the feelings of being imposed upon and improve staff satisfaction (Boswell et al., 2015; Wolpert, 2014).

Specifically, such a platform should consider and communicate what value these changes have for practitioners and their clients.

With this is mind, involving the workforce in the design and development of services could improve job satisfaction and staff retention by increasing their autonomy, or at least perceived sense of autonomy, thus reducing their feelings of disempowerment. Accordingly, within the programme there have been numerous concerns raised about the relatively high turnover rate of PWPs (Moreea, 2015; Pimm, 2015), although the reasons for this are unknown and may represent something positive, such as a promotion. Nevertheless, in considering the findings reported here and elsewhere (Steel et al., 2015; Walklet & Percy, 2014), IAPT practitioners may be feeling emotionally exhausted, leading to increased chances of burnout. Additionally, in pursuing naïve and idealistic targets, being under constant surveillance and scrutiny, plus having to come to terms with the minimising discourse characterising IAPT services, provision is likely to become increasingly challenging for practitioners (Rizq, 2012a). From the findings presented here and in the recommendations from Turpin and Wheeler (2011), it is essential that staff develop strong support networks to combat this.

Training and supervision are likely to be integral to making a practitioner's work as worthwhile and manageable as possible (Robinson et al., 2011; Unsworth et al., 2012). Equally, these practices are useful in coordinating a cultural shift in the workforce according to the accounts included here. Other evidence has also reported its usefulness in overcoming practitioner resistance about certain practices, including the implementation of ROM (Boswell et al., 2015; Lucock et al., 2015; Unsworth et al., 2012). Counter to this, it may not always be possible in light of situational and operational constraints, particularly due to a lack of accommodation, as reported here and discussed in a subsequent section (see Adjusting to Local Geography and Area Context p.230). Significantly, these considerations underscore the need to provide added support and resource to nurture and enable strong inter-professional working relationships.

7.4.6 Preparing Colleagues using IAPT Training and Accreditation

Another interesting finding emerging from the narratives of practitioners was the use of IAPT training and accreditation as a means to protect and ready the workforce. It was almost as though they had a badge of approval, which protected them from being discredited. Such as it is, the IAPT-light services also engaged with this training and accreditation, not seeing much point in pursuing other avenues, seemingly due to the dominance of the IAPT programme in mental healthcare. Certainly, it should be commended that the IAPT programme is promoting and supporting the training of therapists in the provision of Evidence-Based Psychotherapeutic Interventions (EBPIs), especially given that national audit data reports interventions can sometimes be delivered by those who are not fully accredited (RCP, 2013). Furthermore, the practitioners participating in this research regarded IAPT training to be of the highest quality. However, as Shepherd and Rosario (2008) point out, for low-intensity practitioners at least, there is limited actual training involved, with this role mostly requiring a great deal of on-the-job, experiential learning. Similarly, Robinson et al. (2011) found that undertaking an IAPT high-intensity training course left six mental health nurses feeling initially unskilled, while also experiencing a self-perceived shift in identity. These findings imply that undergoing 'IAPT-approved' training is perceived to be fundamental amongst practitioners, despite it only representing a partial tool in the skills and development of a therapist.

Generally speaking, there appears to be a paucity of research regarding effective Cognitive Behavioural Therapy (CBT) training (Rakovshik & McManus, 2010). Alternatively, it may be that the use of more manualised-based approaches is helpful in this regard (Ali et al., 2015; Almlöv et al., 2011); however, it is important that practitioners do not stick too rigidly to the protocol, so as to limit their skill development due to an over-reliance on them (Cairns, 2014; Duncan & Miller, 2006; Papworth et al., 2013; Shepherd & Rosario, 2008). As evidence suggests, personal accounts of practitioners working at these levels have reported difficulties when faced with increasingly complex cases (Bogart, 2015; Jones et al., 2013; Rizq, 2012b; Vail et al., 2012). Then again, it may be unfair to use the term 'manualised', as many approaches still require a degree of therapist input and exploration of a

client's world (Richardson et al., 2010). On balance, it may be that training plays less of a role in a practitioner's skill development and the supervisory practices in IAPT services could support therapists beyond this. Nevertheless, this does not fully support the emphasis on training, or rather 'IAPT-approved' training. It could be that outside pressures on services necessitate this need, raising questions about those who are considered to be 'non-IAPT', particularly if they are unwilling to subscribe to the IAPT delivery model and emblem of approval. This situation could lead to, as Altson et al. (2015) found, a greater exclusion of these therapists. Notably, approximately 19% of the IAPT workforce have not completed IAPT accredited training (n=5,967) (Dance, 2015). In any case, the policy documentation supporting IAPT provision has since been expanded to include other accreditation bodies likely reflecting a growing inclusion of other therapeutic modalities (IAPT, 2012). A key thing to remember is that preceding this change, IAPT training solely opted to use a single accreditation body, itself mainly emphasising CBT models (IAPT, 2009). Therefore, as services begin to expand their scope and include a wider range of therapies, the programme will need to collaborate with other accredited training bodies for the benefit of practitioners and their clients.

7.4.7 The Functionality and Adaptability of the IAPT Delivery Model

According to Damschroder's et al. (2009) Consolidated Framework for Implementation Research, it is important to consider the characteristics of the intervention for implementation; in this case the IAPT delivery model and its approach. The IAPT delivery model represents a unique innovation in the provision of psychological therapies, providing greater equitable access to EBPIs (Cavanagh, 2014; Layard et al., 2012). The utility of stepped-care and manualised therapy means that practitioners were able to modify their service and become more accommodating, allowing them to be a more responsive service. This was important as the key to implementation was essentially a process of seeking integration. However, this activity was highly iterative, characterised by a series of dynamic and nonlinear processes, each of these influenced by a number of complicated and multifaceted factors. Despite remaining faithful to the fundamental delivery model, it was considered important to adapt the approach to become a locally relevant service. It was clear that the local area context played a prominent role in the implementation

process, as did the evolving context at a macro-level, resulting in a need for constant change. The sheer level of change suggests that cross-sectional analyses of service delivery and the implementation of new innovations will bear some important limitations (Clark et al., 2009; HSCIC, 2014a, 2014b; RCP, 2013), supporting the need for more longitudinal-based research and process analyses.

These narratives support the use of stepped-care models for the flexible application of interventions within a complex service setting and context. Equally, it could potentially lead to improved service efficiency (Gyani et al., 2011) and cost-savings (Hammond et al., 2012). Nevertheless, the organisation of this model seemed to be very much influenced by the availability of staff and their expertise, in keeping with other evidence (Glover et al., 2010; Richards et al., 2012; Sharp et al., 2014). Similarly, for those practitioners feeling isolated as a service, the links beyond and between other institutions represented a challenge. This will likely have an impact on the efficiency of a stepped-care model (Delgadillo et al., 2013; Lucock et al., 2015; RCP, 2013), particularly in services only providing treatment for step-2 or step-3 interventions. In short, this reveals that the adaptability of the IAPT delivery model is good within practice, however the mediating pathways between sectors represent the biggest obstacle regarding its functionality.

7.4.8 Adjusting to Local Geography and Area Context

One of the largest influences on implementation was the circumstance in which services were located. This included the local geography, transport links, casemix, accommodation, and links to other services. It may reflect the complexity of socio-demographic factors on the wellbeing of an individual, thus producing different area priorities (Barkham et al., 2012; Black, 2008; Marmot et al., 2010; Wilkinson & Pickford, 2009). Equally, it may emulate the variation in approach and delivery model implemented between areas, as illustrated in other services responding to their catchment area needs (Clark et al., 2009; Glover et al., 2010; IAPT, 2008; Richards et al., 2012; Sharp et al., 2014). To put it another way, this corroborates the need for a flexible and adaptable model that is able to respond to local area context and macro-level pressures. Moreover, considering the clients' poor awareness about services, together with other evidence reporting similar trends (Hamilton et al., 2011;

RCP, 2013; Savage et al., 2015), greater community engagement is likely warranted, especially for hard-to-reach groups or services in geographically challenging areas. Trends such as these may be mitigated if the awareness of services were improved, implicating the need for greater community engagement and education (Brown et al., 2014; Jamieson & White, 2008; Turner, 2015; Watts & Robjant, 2008). All things considered, it is imperative that the work required beyond the service boundary is recognised, as opposed to solely focusing on practices in silos.

Generally speaking, a source of continual strain for practitioners was requiring to locate and manage accommodation, or lack thereof, particularly regarding the training and supervision of the workforce (see Preparing Colleagues using IAPT Training and Accreditation p.228). Many negotiated a room booking in GP practices, which had the added benefit of developing a relationship with GPs. Shepherd (2014) reported that limited accommodation acted as a restriction for including the family in the therapy session, despite practitioners acknowledging their involvement was beneficial. Similarly, a consideration for a client's mobility also played a role, with over-the-phone and computer-based therapy favoured in harder-to-reach areas. In light of this, it appears that there are numerous other factors influencing the delivery of treatment beyond the scope of the therapy session. Consequently, this underscores the need to recognise the complex and integrated nature of the implementation process impacting on therapy in a clinical setting.

7.4.9 The Role of the Service for Clients

Many of the factors affecting service engagement and client experience were actually beyond the control of the service. Nevertheless, these factors were important because of what the service then came to represent; in this instance, a break from the stresses of life, typically prominent in the home environment. Moreover, it may be why therapy delivered over-the-phone was a concern for this group (Hammond et al., 2011) (see The Autonomous Client: Overcoming Barriers and a Difficult Transition p.239), further highlighting the importance of an accessible location. Because of the central role the service played, the atmosphere and environment were particularly decisive. Hamilton et al. (2011) found that providing a welcoming atmosphere and accessible location, with approachable staff, was essential. Accordingly, the findings

presented here support this. Fortunately, as stated by the client group, the location of services was better than expected and greatly valued. The location allowed clients to gain ownership over their engagement, describing the actual journey itself as an achievement. This, therefore, suggests that the location and environment of a service setting, including the client's physical journey to get there, was beneficial, therapeutically. To this end, in spite of the growing inclusion of telephone and computer-based therapy, the location and transport links into a service are still extremely important and should not be neglected in favour of an increased use of these technologies.

7.5 Coherence: Sense-Making Work

7.5.1 Protecting and Enhancing the IAPT Programme by Assuming a Classification Certainty

The NPT core construct 'coherence', refers to the sense-making work that people do, either individually, or collectively when attempting to operationalise a set of practices (May et al., 2010). The basis on which the IAPT programme was framed, that is, around the classification of discrete conditions, treatment manuals, supervision, ROM and guidance for organising the workforce, offered clarity and therefore reassurance in the approach towards the operation and implementation of services. Aligning more stringently with guidance, and in so doing enhancing treatment fidelity, was considered essential to boosting service efficiency and effectiveness; this being an approach championed by leading implementation research advocates (McHugh, 2010; Schoenwald et al., 2011). Under these circumstances, the IAPT delivery model is characteristically more in line with a research trial, as it standardises treatments (via supervision, training and treatment manuals), as well as incoming clients (via diagnoses and inclusion criteria). Such practices have real-world value as evidence suggests that remaining faithful to treatment guidance is likely to improve outcomes (Gyani et al., 2011; Shafran et al., 2009) and reduce practitioner variation (Ali et al., 2015; Almlöv et al., 2011). Accordingly, this corroborates with the narratives in this research, favouring an approach that reduces variability and thus achieves more equitable access to a

therapist. However, the consequence of this is a need to implement more control over who is accessing the service, so as to achieve greater accuracy.

This process requires differentiating incoming clients, making their conditions distinct from one another by using a categorical, diagnostic-based approach. This is likely due to the wider narrative emphasising EBPIs, which determines treatment effectiveness by focusing on discrete conditions. It ensures the systematic application of best research practice as work is better operationalised by directing effective interventions for particular conditions, thus deriving a greater output. Indeed, it was clear the IAPT initiative offered participants a real opportunity to bring about change, overcoming the challenges and shortfalls that had characterised provision previously. The task in itself became more orderly and therefore, easier to understand, enabling practitioners to structure services more systematically, being confident and assured in their doing so. This appeared to act as an emotional charge, similar to findings reported by Steel et al. (2015), who found that feelings of personal accomplishment among IAPT practitioners acted to contain experiences of emotional exhaustion. For this reason, feelings of pride and gratitude likely enhance the approach towards care.

For clients, identifying with the IAPT delivery model encouraged them to stay engaged, having seemingly been on a search for meaning and understanding about their own distress. Issues were reported when a number of clients spoke of their general discomfort for the terminology used by the service, which served to challenge their identity and perception of themselves. Accordingly, comparable evidence in this area reports similar experiences (Badelley, 2014; Hamilton et al., 2011; Khan et al., 2007; Savage et al., 2015). The point of access was characterised by a moment of revelation, as though their search for meaning had been achieved. However, it should be noted that the point of access was considered to be overwhelming and arguably the most upsetting part of a participant's experience (see The Autonomous Client: Overcoming Barriers and a Difficult Transition p.239). This appeared to be a result of confronting issues they had been in denial about for a prolonged period of time. In any case, it seems that services ought to be well equipped to comfort clients and facilitate their search for meaning and understanding.

7.5.2 Clients who are not Fitting the Model and Gaps in Services

In many ways, opting to treat discrete conditions was intended to remove any interference in service provision that may make things difficult. Similarly, it also meant taking an active approach to ensuring that practitioners worked within their treatment boundaries. Although sticking to this model was considered best and most effective practice, there are a number of concerns which accompany this, namely treating those who do not fit the model. It should be said that there are many who consider the usefulness of a categorisation system for mental healthcare to be problematic, due in large part to the subjective, arbitrary, overlapping and unreliable nature of determining a diagnosis (Bentall, 2004; Mollon, 2009; Guy et al., 2012; Loewenthal, 2015). Such considerations are amplified when referring to CMHPs with critics labelling the approach as a means to medicalise unhappiness (Dowrick, 2004; Mollon, 2009; Moloney, 2013; Rizq, 2012b), indicating that its use for these conditions is not entirely appropriate.

The detrimental impact of this approach can be illustrated by the participants' concern for gaps in services, something that has been reported elsewhere (Byng et al., 2011). This concerns clients who are too severe for primary care, but not severe enough for secondary care, or those clients who may not be receptive to the choice of treatments available. The allocation of responsibility between services was a source of contention among practitioners, with many expanding their services to capture clients falling through these gaps. This was especially the case for those who felt isolated and solely responsible for their respective area, again corroborating with findings reported by Byng et al. (2011). Gaps are likely an artefact of attempting to apply order, via the use of treatment manuals and narrow diagnoses, to a complex area such as mental healthcare. It also helps to highlight the need for whole-systems thinking, which considers the mediating pathways and strives for integrated care; a concept that will be discussed in a subsequent section (see Whole-Systems Thinking p.250).

A key thing to remember is that this approach runs the risk of favouring a positivist discourse, becoming more about exclusivity than inclusivity. Moreover, its proponents are encouraged by a false certainty who, although are aware of the issues,

wilfully ignore them (Guy et al., 2012). Consequently, clients are abstracted by an uncertain diagnostic categorisation process, gearing services towards a move to recovery for a client group fitting a very particular model, with recovery taken to mean the reduction in symptoms, rather than focusing on the strengths and identity of the client (McPherson et al., 2009; Weinstein, 2010; Williams et al., 2012). Rizq (2012a, p.9) refers to this, and the use of ROM in IAPT services, as a "'virtual reality' where attention to targets, outcomes, protocols and policies is privileged over attention to the patient's psychological care". This, Rizq (2012a, 2012b) argues, ultimately leads to an instrumental view of the human condition, as clients are judged based on their appropriateness and utility for the service. These instances were apparent in the experiences of practitioners who spoke of encountering difficulties when attempting to treat clients who do not fit the model, fully aware of the fact that their treatment outcomes would likely decrease in doing so. Although upholding their duty of care and not denying clients access to treatment, this ultimately led to tensions and a possible apathy about this circumstance. Consequently, this highlights a potentially growing concern, as although those involved in the operation and provision of services are likely compassionate, the system in which they practice may ultimately lead to a depersonalisation of clients. Thus, it appears that the basis on which to focus the delivery model might be problematic and in need of re-assessing.

7.5.3 The Referral Practices of Others

Poor referral practices of other health professionals appeared to make provision difficult, with a number of inappropriate referrals being received. It was described that the confusion resulted from the fact that IAPT services had become synonymous with psychological therapies in general, themselves becoming a repository for any and all conditions. This is perhaps due to the subjective nature and shared symptomology of diagnostic labelling for CMHPs, making diagnosis among other practitioners difficult to specify (Bentall, 2004; Dowrick, 2004; Mollon, 2009; Guy et al., 2012). Notably, poor diagnostic practices of referring health professionals have been reported previously (Clark et al., 2009; Glover et al., 2010; Stern et al., 2015). For instance, around 95% of all clients being referred into the Doncaster demonstration site by GPs were labelled as having depression, yet the Newham

demonstration site, which used in-house staff doing a diagnostic assessment using the International Classification of Diseases (ICD-10) system, reported diagnoses as 46% depression, 43% anxiety disorders and 12% other disorders. Similarly, there is evidence to suggest CMHPs among the population are under-recognised by GPs (Clark et al., 2009; Evans-Lacko et al., 2013; Gyani et al., 2012). Therefore, implementing a stricter approach for managing incoming clients is likely difficult under these circumstances. Certainly, participants spoke of having a responsibility to support all clients up until they can find more appropriate care, leading some practitioners to be working beyond their competency, a similar pattern to which has been reported nationally (RCP, 2013). In short, this will likely impact on client care, safety and move to recovery, demonstrating the need to acknowledge and engage with these pathways.

To better control their service and improve access, practitioners were increasingly emphasising self-referral techniques, so as to move the identification process and assessment into services. In doing this, they were able to identify and potentially signpost clients who were deemed to be unsuitable in respect of the inclusion criteria. Also, it was believed that clients would be able to access treatment sooner, as it removes the barrier of having to consult with a GP. Evidence has reported self-referral not being available across all services (Brown et al., 2010) despite it being associated with an improved representation of population casemix (Brown et al., 2014; Clark et al., 2009; Green et al., 2013), increased referral rates (Green et al., 2013) and clients moving to recovery sooner (Clark et al., 2009). This translates to the responses of practitioners perceiving self-referral as a means to confirm the commitment and motivation of the client, with those accessing via this pathway likely being more motivated. In any case, it is important that services still include the GP in this process, as practitioners and clients included here will attest to; this being similarly recognised by Layard et al. (2012). Accordingly, the role of the GP will be discussed further in a subsequent section (see Engaging with GPs p.253).

7.5.4 Predicting Complexity While Increasing Throughput

Returning to the concept of implementing more control at the start of services, it is interesting to note that this meant attempting to reduce complexity about a client's

condition. One reason for attempting to get things under control initially was that it was generally considered difficult to modify treatment once a client was in therapy. This was especially challenging as the complexity of a client's condition was not always revealed up until them actually being engaged with a therapist. When exploring the decision-making processes about whether to step-up a client or not, Delgadillo et al. (2013) found that the perceptions and beliefs of a therapist greatly influenced the process, more so than treatment guidance or a lack of progress on ROM. Similarly, other evidence involving a greater number of participants have reported a low stepping up rate within services, with proportions of high to low-intensity practitioners also varying widely between services (Glover et al., 2010; Radhakrishnan et al., 2013; Richards et al., 2012). From the client's perspective, it may be that stepping up is difficult in light of a strong therapeutic bond, or due to a client's initial uncertainty about their condition, including what their needs are. It may also be due to the belief that ongoing care is not available (Delgadillo et al., 2013), something that certain practitioners in this research struggled with, especially in isolated areas. Thus, it appears to be important for services to provide the right course of treatment early on. That said, the pressures on services to increase their throughput may leave little option but to emphasise stepped-care models, as opposed to more stratified approaches. This can be demonstrated by a therapist's perceived rush and urgency in treatment provision within IAPT services (Haarhoff et al., 2015). Furthermore, this and other operational constraints may lead to a greater use of cheaper innovations, such as delivering treatment over-the-phone. It may also lead to an increased use of inexperienced staff in the assessment session, creating difficulties for those who do not feel adequately trained or prepared to help (RCP, 2013), leading to anxiety and feelings of failure (Rizq, 2013).

Therefore, these factors risk providing unsuitable treatment to clients with increasingly severe and complex issues. This is increasingly problematic when considering how much a client is willing to open up in the early stages with someone who, as reported here and elsewhere (IAPT, 2009; Turner, 2015; Wolpert, 2014), is essentially a stranger. The implication of this is that there is likely a definite need to improve the transition of steps in care, including from primary to secondary care. Alternatively, services should focus on the initial stages of access and engagement so as to accurately judge the necessary course of treatment. The findings discussed in

this report, and in other evidence (Cairns, 2014; Di Bona et al., 2014), would suggest this approach is preferable from a client's perspective. On balance, it is vital that increasing throughput does not interfere with the service's ability to accurately identify and treat increasingly complex cases. Thus, the central factor in this becomes about balancing quantity versus quality of care.

7.5.5 The Role and Variable Nature of Assessment

These concepts require that the role and purpose of the assessment session need reconsidering. The stage of assessment is crucial to the function and operation of IAPT services. Evidence suggests that a sizeable proportion of clients fail to ever make it into therapy (Glover et al., 2010; Griffiths & Steen, 2013a; Richards & Borglin, 2011; Stanton, 2012), with around half of all referrals dropping out or declining treatment (HSCIC, 2014a, 2014b; Richards & Borglin, 2011). A key thing to remember is that approaching a service can be fraught with uncertainty and confusion and will, therefore, have an implication on the assessment session (Eliacin et al., 2014; Savage et al., 2015; Spratt & Carey, 2009; Turner, 2015), particularly if it has an influence on client disengagement.

With this in mind, there appeared to be great variation in the approach towards assessment between services, all of which differed in their format and use of staff. Similarly, the role of assessment has been found to vary across other services (Cairns, 2014; Di Bona et al., 2014; Glover et al., 2010; Mathers & Mitchell, 2010; Vails et al., 2012), as has the level of stratification involved beyond this stage (Richards et al., 2012). Evidence suggests that it might be worthwhile to invest in a robust assessment session to identify characteristics that might impact on a client's engagement and recovery (Grant et al., 2014; Green et al., 2015). In this study, practitioners provided their own rationalisation and justification for each approach, with certain services less inclined to involve more experienced staff on account of the demands on their service, including geographical constraints and staff availability. These factors also influenced the decision to incorporate a greater proportion of conducting risk-assessment over-the-phone. Notably, practitioners also varied in their attitudes towards the assessment session. Some considered it a necessary space to explore a client's issues in order to allocate them to the right level

of care. Whereas other practitioners were eager to get a client into therapy as quickly as possible and forgo any prolonged and anxious waiting time. At present, there is limited evidence available regarding how best to organise the use of stepped versus stratified care approaches. However, it is important that those opting for a greater proportion of stepped-care and low-intensity provision do not sacrifice quality in the interests of quantity.

7.5.6 The Autonomous Client: Overcoming Barriers and a Difficult Transition

Overall, a client's experience about their engagement with a service was mostly positive, echoing the findings of Brazier and Connell (2014). What appeared to boost positivity and enhance client agency was considering the treatment as a kind of privilege. This attitude was essential, given the reportedly difficult experiences associated with accessing a service that required overcoming feelings of denial, vulnerability and uncertainty. In keeping with the literature, behaviour during this stage was characterised by an attempt to conceal one's condition from others (Barnes, 2011; Cameron et al., 2012; Vogel et al., 2009), as well as seek anonymity during treatment (Kenwright, 2009; RCP, 2013). In particular, help-seeking was low, with clients likely attempting to deal with their issues on their own, similar to trends found in larger samples (Anderson & Brownlie, 2011; McManus et al., 2009). It may also be due, in part, to feelings of shame, confusion and stigma (Barnes, 2011; Carey et al., 2008; Savage et al., 2015; Vogel et al., 2009). Confronting these issues and overcoming the perceived barriers was deemed necessary to make a worthwhile change (Barnes et al., 2013; Easby, 2010; Hayes et al., 2007). Consequently, clients sometimes made sense of their experiences by considering those who may not be fully engaged with a service, taking on a kind of 'no pain, no gain' mentality (Barnes et al., 2013; Easby, 2010; Hayes et al., 2007). The difficult transition into services links in with the findings of practitioners regarding testing a client's commitment (see A Target-Driven Practice Emphasising Quantity and Throughput p.221). Therefore, therapeutic engagement in IAPT services, or even in general, requires that clients push beyond boundaries in themselves, so that they feel able to commit.

That said, there were various barriers implemented by a service that seemed to test this commitment further, usually centring around the initial stages of access. Practitioners emphasised the sensitivity of clients during these stages, and indeed much of the implementation process was influenced by finding ways to improve provision here. Firstly, a poor awareness about services created several false and negative expectations regarding treatment, seemingly as a result of uncertainty and fear about treatment (Hammond et al., 2011; Turner, 2015). Alternative evidence has also identified negative preconceptions such as these acting as an inhibitory factor, leading clients to delay or avoid access to health services (Anderson & Brownlie, 2011; Evans-Lacko et al., 2013; Savage et al., 2015; Turner, 2015). Moreover, a GP's awareness about IAPT services might be poor (Gyani et al., 2012; RCP, 2013), as is the recognition for CMHPs in the population, particularly among Black and Minority Ethnic (BME) communities (Clark et al., 2009; Kendrick et al., 2009; Lovell et al., 2014). Some have suggested the use of a self-referral pathway for overcoming these barriers so as to enhance access, as well as overcome language, ethnic and cultural barriers (Brown et al., 2014; Clark et al., 2009; Gaynor & Brown, 2013; Green et al., 2012). However, considering the responses from clients here and in keeping with other evidence (Brown et al., 2014; Jamieson & White, 2008; Watts & Robjant, 2008), this will likely require greater community engagement. On the basis of the evidence, it suggests that the initial stages of engagement deserve added attention, with efforts crucially needed to remove barriers, catering to client sensitivity and uncertainty.

In particular, the type of questioning used was considered to be particularly impactful, leaving clients feeling vulnerable and confused. Participants varied with how receptive they were to the medical terminology used, emulating findings reported by Badelley (2014) and Scott (2010). Labels such as 'patient' were distressing and felt by some to be depersonalising while for others it instilled feelings of hope about eventually being 'cured'. It could also be that the current biomedical underpinnings of modern-day mental health services discourage clients in their access to treatment (Anderson & Brownlie, 2011; Bee et al., 2008; Easby, 2010; Hamilton et al., 2011; McManus et al., 2009). Constructing a sensitive dialogue about the use and type of language, including how this might impact on their sense of

self, is important for services and practitioners to consider, as it likely varies on a case-by-case basis.

In this instance, it was possible to gain insight into a client's experience who struggled speaking English, herself part of a minority ethnic group. Evidence in this area is currently limited and based on small participant numbers (Bassey & Melluish, 2012, 2013; Costa & Briggs, 2014; Jamieson & White, 2008; Mofrad & Webster, 2012; Watts & Robjant, 2008); however, it is important to recognise that Maria spoke of her positivity regarding the adjustments made during her time with a service (Watts & Robjant, 2008). Maria was also responsive and accepting of the use of an interpreter during therapy, corroborating with other research (Costa & Briggs, 2014). These findings illustrate that the IAPT delivery model was accommodating to Maria's cultural and linguistic needs and ought to be celebrated. It is worth remembering that several innovations within the programme have been trialled and tested to enhance access for hard-to-reach groups, which from the evidence here and elsewhere, looks positive. Nonetheless, this is still based on small sample sizes supporting the need to undertake further research in this area.

Difficult emotions in the early stages were further intensified considering the fact that the practitioners were essentially a stranger, making opening up to them difficult. The stranger effect has been reported elsewhere (Wolpert, 2014) and may make engaging BME groups difficult (IAPT, 2009). In line with other research findings (Baddeley, 2014; Hammond et al., 2011), clients found the use of a phone for assessment and treatment to be challenging. Consequently, this made the stranger effect even more apparent, as the practitioner was removed physically, demonstrating a desire for a more humanising approach to treatment (Marks & Cavanagh, 2009; Richardson et al., 2010; Waller & Gilbody, 2009). Notably, feeling a connection in therapy was useful for a client in gaining insight into their inner self, with each emphasising and cherishing the therapeutic relationship. In contrast, the use of a telephone was regarded as providing a lack of depth, echoing the findings of Hamilton et al. (2011). The evidence reveals a generally mixed picture about the acceptability of the telephone for therapy and assessment. Some may be welcoming of it (Bee et al., 2008; Lovell, 2010; Turner, 2015), with its use being more convenient for the client (Kenwright, 2008; Mansell, 2007; Bennett-Levy et al.,

2010) and also the service (Hammond et al., 2012). Indeed, for Sarah and Rachel, it afforded them a safeguard of anonymity, supporting arguments proposed by Kenwright (2009). However, depending on your perspective, the fact that it is easier to hang up the phone and disengage could be considered a notable disadvantage. In advance of using over-the-phone assessment techniques, practitioners ought to recognise and acknowledge the potentially overwhelming and difficult emotions clients may be experiencing at this time (Bennett-Levy et al., 2010). Moreover, these factors underscore the value in prioritising client need and safety ahead of apparent gains in service efficiency.

For the most part, practitioners generally appreciated the use of a phone format for assessment and for enhancing access, much in the same way that was reported by Jones et al. (2013), although their study reports a greater concern among practitioners about its suitability. In this study, it may be due to the variable nature and role of assessment in participating services (see The Role and Variable Nature of Assessment p.238). Specifically, there is evidence to suggest concern for this practice, having been associated with re-referral and greater dropout in cases of greater complexity (Cairns, 2014; Di Bona et al., 2014). Equally, it may lead to greater stress and possible burnout among the workforce for those who feel ill-equipped and confused in their role (Rizq, 2011). Regardless, ongoing organisational refinements had apparently led to a greater use of over-the-phone based techniques, likely due to a need to meet an increase in demand. Then again, this was not always welcomed by a service's workforce according to practitioners, although responses did vary.

These help to characterise the difficult first stage clients experienced in accessing a service. Notably, the highest proportion of disengagement tends to occur early on in the patient pathway (HSCIC, 2014a, 2014b; Richards & Borglin, 2011; RCP, 2013), possibly indicative of a difficult transition. While provision clearly needs to put specific procedures in place, at times this could make access especially challenging. Certainly, those entering a service required a great deal of determination and autonomy to access treatment. However, perhaps paradoxically, these traits are likely at their lowest when suffering from a CMHP. The need to overcome barriers may reflect a consumerist ethos that underpins modern-day health services and

emphasises a culture of self-reliance and self-coping (Rizq, 2012b; Scanlon & Adlam, 2010; Walker, 2012). This ethos is evident within the IAPT programme, with its increasing emphasis on low-intensity interventions and use of self-referral pathways. Consequently, this may portray those who do not access treatment as being a failure to act (Scanlon & Adlam, 2010), rather than the result of contextual and service barriers. Clients similarly shared in this attitude, suggesting that those who do not engage could experience feelings of self-guilt and blame, either from others or within themselves, likely worsening their condition. Therefore, it is important that services do not emphasise individualistic approaches and instead find ways to enable incoming clients to have faith in their own ability, thus avoiding potential disengagement.

7.5.7 Building Confidence in the Intervention

Language is believed to be important for relational working and boosting client enthusiasm in an intervention (Bennett-Levy et al., 2010; MacDonald et al., 2007). In support of this, therapy was highly revered and positively received by clients when considering the endorsement of others. In negotiating treatment, it is necessary to ensure that each type of intervention has an equal footing so as to not coerce the client into thinking one is 'superior' over another (Bennett-Levy et al., 2010; McDonald et al., 2007). Indeed, the optimistic drive and language of the IAPT programme, while criticised by some for its impact on staff (Rizq, 2011; Marziller & Hall, 2009), may be helpful in boosting a client's confidence and initial motivation to engage with treatment. Similarly, the recommendations in NICE guidance and commitment from central government might place these therapies in good stead. Nevertheless, a negative impact of this might exacerbate feelings of guilt and self-blame if a client cannot engage in treatment (Rizq, 2012b), a situation that could be likely in consideration of the findings and research literature discussed here.

7.6 Reflexive Monitoring: Appraisal Work

7.6.1 Appraising the IAPT Programme

The NPT conceptualises a core construct of social action during implementation to be reflexive monitoring. This monitoring refers to the appraisal work that individuals take part in to assess and understand the ways that new practice affects them and others around them (May et al., 2010). The process of monitoring was found to take on many forms, including the use of ROM, client narrative, or hands-on experience, either involving the practitioners or their colleagues. Data collection was considered an absolute cornerstone of the IAPT delivery model, with Melissa even remarking that she was incredibly proud of her service's data collection. It possibly contrasts poor levels of data collection in other areas of mental healthcare (Jacques, 2008; Stiles et al., 2006, 2008), which likely leads to service quality improvement becoming challenging (Addicott et al., 2015; Appleby et al., 2015). There are some who consider the use of ROM in a clinical setting to be an integral part of service quality improvement, as well as informing practice-based evidence (Barkham et al., 2010; McHugh & Barlow, 2010). Their use is also helpful for enhancing treatment fidelity (McHugh et al., 2009; Schoenwald et al., 2011) which, according to the accounts reported here, was fundamental to a service's success.

The reason for high levels of data collection is largely due to the use of session-to-session recording practices (Clark et al., 2009; Gyani et al., 2011), and a stipulation from the IAPT central team requiring services achieve at least a 90% data completion rate (IAPT, 2008). Nonetheless, data completion between services, particularly during the early stages of the programme's dissemination, has varied widely (Delgadillo et al., 2013; Glover et al., 2010; HSCIC 2014a, 2014b). Moreover, there are certain fields in the dataset that often don't achieve a 90% data completion rate, notably those for recording a client's ethnicity (Glover et al., 2010; HSCIC 2014a, 2014b), making analysis and subsequent service improvement difficult. In any case, this practice is clearly an important component of the IAPT programme, with participants included here seemingly putting great value on it. Overall, it seems that there are many benefits to emphasising and implementing this practice, which I will now discuss.

7.6.2 Reflective Practice during Implementation

Characterising implementation was a series of iterative processes, hence it was useful for practitioners to take a moment and reflect on certain innovations. Considering the uniqueness of the IAPT delivery model, including its ambitious underpinnings, this is understandable. Those implementing services are charting an unknown terrain with psychotherapy now taking a central position in government policy. It was considered helpful to incorporate a reflective space to help refine services and take note of what works. The use of this space is particularly important considering the apparent rate of change in service operation and initial rush during early implementation, as discussed in another section (see Adjusting to Change p.220). In particular, the use of ROM afforded practitioners' live feedback about the implementation process and ongoing innovation. For instance, if there was no foreseeable impact on the Key Performance Indicators (KPIs) from implementing a new approach, then the modification would be considered justified. Using ROM as a tool for reflective practice as a way to improve IAPT services has been reported previously (Delgadillo et al., 2014b; Green et al., 2013), further supporting their use for service improvement. Thus, the use of ROM can help inform practitioners, clients and national developments of the programme for future reflective practice (Clark et al., 2009; Gyani et al., 2011). Notwithstanding, it is necessary to recognise the limitations inherent in this approach.

Constructing service effectiveness requires taking into account other factors beyond calculating the recovery rate. Under these conditions, only certain aspects of provision are considered, risking measuring the wrong thing and creating a false reality. For instance, by considering the level of client disengagement and dropout in services, the rate of treatment effectiveness has been found to reduce substantially (Barkham et al., 2012; Glover et al., 2010; Griffiths & Steen, 2013a; Stiles et al., 2006, 2008). Evidence also suggests that those engaging with IAPT services may not be representative of their catchment area (Brown et al., 2014; Delgadillo et al., 2014b), leading to high levels of unmet need for certain population groups. Furthermore, given the high rate of disengagement early on in services, it would be useful for assessment to focus on the stages of referral and access. Consequently, this would corroborate with the experiences of the client group included in this research

regarding their challenging transition into accessing services. When evaluating service improvement, it is vital that individuals understand what the data means and more importantly, who it represents. Equally, it is crucial that top-down pressures are aware that by emphasising on targets in one area, there could be detrimental impacts in another. In any case, it is important that the programme does not remain fixated on data, assuming it is the only answer when, in fact, it is quite the contrary. Data is only a counterpart of reality and so while it may be integral to making decisions, practitioners should recognise that it can be unreliable, unfaithful or even misleading.

7.6.3 The Therapeutic Benefit of using ROM

The use of IPA can lead to new and unexpected findings (Smith et al., 2013; McEvoy et al., 2014). In this instance, it was discovering the way in which both clients and practitioners referred to the progress on treatment scores for encouraging their engagement. It appeared that observing the changes in scores could provide an additive therapeutic benefit, almost as a way to challenge a client's blind-sidedness regarding their improvement. Much of the research advocating the use of ROM has evolved as a means to overcome therapist blind-sidedness, as it helps to identify clients at risk of deteriorating (Lambert, 2010; MacDonald & Mellor-Clark, 2014; Shimokawa et al., 2010). Likewise, systematic review evidence also supports its usefulness for improving service effectiveness in clinical settings (Boswell et al., 2015; Knaup et al., 2009). As a result of ROM and close case management, it is believed that service efficiency can improve as it allows individuals to challenge practitioners holding on to clients unnecessarily (Delgadillo et al., 2013), thus prioritising their time (Delgadillo et al., 2014b; Hammond et al., 2012). However, in considering the themes reported here, improvements in service effectiveness could also be the result of clients feeling more encouraged using ROM and therefore, more likely to stay engaged. Moreover, other evidence also reports a positive attitude towards ROM among clients (Gellatly, 2011; Unsworth, 2015). Accordingly, this corroborates with the arguments put forward by Youn et al. (2012) who notes that even the most sceptical of clients can be reassured by observing their improvements in scores. Equally, reflecting on changes between the first and last session seemed to serve as a powerful tool, seemingly providing clients with a means of validating their engagement and move to recovery as genuine. From the practitioners' perspective,

these scores were useful for communicating and validating their own skills and ability to the client. Thus, ROM may provide a higher order function that benefits the therapeutic relationship and stimulates engagement.

Although this may be true, it was reported that sometimes scores may not always reflect reality or be in line with a client's understanding of their own distress and concept of recovery. Not using these measures sensitively enough could have a detrimental impact on therapy and the therapeutic encounter (Boswell et al., 2015; Wolpert, 2014). Similar to findings reported elsewhere (Brazier & Connell, 2014), this was due to the restrictive nature and subjective phrasing included in the measures. This also resonates with Delgadillo et al. (2014b) who reported that, in advance of the penultimate session, using treatment scores to predict client dropout was ineffectual. On the basis of this and other evidence, including measures that account for both the experiences of coping and do not inhibit the voice of the client is likely warranted (Böhnke et al., 2014; Rao et al., 2010; Reininghaus et al., 2011; Weinstein, 2010). Accordingly, this links in with the high regard and value that practitioners placed on client narrative (see Making Greater Use of Client Narrative p.250).

7.6.4 Incorporating other Types of Reflexive Monitoring Techniques

Rather than focus on the alleviation of symptoms, provision could consider the use of multiple measures for recording. The IAPT programme already advocates the use of multiple measures for determining a move to recovery, ensuring that a service looks at the welfare of the individual rather than one specific symptom, with other evidence also supporting this need (Böhnke et al., 2014; Reininghaus et al., 2011). Similarly, it is also necessary to account for casemix and socio-demographic factors, with research currently underway about how to incorporate these, as well as the necessary risk-adjustments (Delgadillo et al., 2014a; Grant et al., 2014). Conversely, certain measures such as the Work and Social Adjustment Scale (WSAS) or Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), which also report on work and social functioning, have been reportedly more difficult to implement (Clark et al., 2009; Glover et al., 2010; Hammond et al., 2012; Rao et al., 2010), perhaps because they take longer to administer. Although this may be true, Turpin

and Fonagy (2010) suggest using the CORE-OM for improved comparability between populations. Considering the current variation in treatment scores nationally, plus the concerns about emphasising a restrictive, symptom-reduction based approach, increasing the use of these measures may be justified. Moreover, it could potentially reduce perverse incentives in care regarding 'cherry-picking' clients, or decrease feelings of resentment and stress for clients who do not fit the model (see Protecting and Enhancing the IAPT Programme by Assuming a Categorical Certainty p.232).

This circumstance may either be helped or hindered by the advent of Payment by Results (PbR), which attempts to account for the many other factors beyond the narrow view of scores developed using ROM; however, the evidence for this is still in development (Perton, 2013). There have also been some concerns raised by health commissioners about the strategy underpinning PbR, which seeks to use treatment scores for reimbursement, thus misconstruing their original function solely to assist the practitioner (Griffiths et al., 2013). Similarly, others have highlighted the inherent neoliberal undertones associated with this oncoming system that again further emphasises a target-driven practice over psychological relatedness and dependency (Rizq, 2012b; Scanlon & Adlam, 2010; Walker, 2012). In view of this, it seems necessary to reassess the use of ROM for reimbursement purposes, especially if it favours a system that treats clients on the basis of fitting a particular model. Moreover, given that these measures do not always reflect how a client understands their own distress and recovery process, this raises further concerns over what is truly being reimbursed, holistic care that emphasises resilience, or merely the removal of symptoms.

Given the value of reflexive monitoring for implementation, in addition to their well-regarded use for clients in therapy, effort should be undertaken to discover ways of accounting for multiple aspects of client wellbeing. It will need to consider the impact on time in therapy in addition to any possible practice and fatigue effects (Boswell et al., 2015; McCambridge et al., 2012). Subsequently, this has led some to suggest identifying possible transdiagnostic factors of CMHPs (Böhnke et al., 2014; Reininghaus et al., 2011). Equally, for clients included here, and in other evidence (Barnes et al., 2013; Price, 2011), the act of actually seeing the scores written down

initially was reportedly difficult to confront. While ROM appears beneficial and positively received (Badham & Young Minds, 2011; Gellatly, 2011; Unsworth et al., 2012), concerns such as these ought to be addressed to avoid confusion and possible stress. As Boswell et al. (2015) rightly point out, this will require extensive client engagement as systems that are poorly designed without stakeholder interest in mind will likely be short-lived.

For both practitioners and clients, the use of ROM was a complicated process. The former realised how vulnerable it is to certain perverse incentives, requiring that they resist the temptation to 'cherry-pick' incoming clients. This effect has been shown in other evidence demonstrating it being more difficult to cross a clinical cut-off point if the initial treatment score is high (Griffiths & Griffiths, 2015; Goddard et al., 2015; Gyani et al., 2011). Fortunately, service evaluations have started to consider treatment score improvement (Clark, 2014; Jacobson & Truax, 1991) which, when referring to the interview responses and open-access data, appears to be a favourable approach. For clients, attitudes were usually positive, although some did recognise their susceptibility towards demand characteristics and false reporting. Again, this further highlights a risk inherent in the current system that emphasises a change in outcome scores as though they are objective when they are in fact distinctly subjective.

Implementing ROM practices represented one of the main occurrences requiring a cultural shift in the workforce, corroborating with other findings (Lewis, 2012; Unsworth et al., 2012). However, practitioners did not appear to feel anxious about being under constant surveillance and scrutiny, as suggested by Rizq (2012b). Instead, practitioners embraced the practice mainly for supporting therapist and service improvement. Rather, it was the optimistic and unrealistic targeting that went along with it which appeared to be difficult to manage. The programme's emphasis on data collection, mainly as a means to demonstrate the effectiveness of the initiative is considered critical for sustained investment (McHugh & Barlow, 2010). Monitoring a service was considered to be, and undeniably is, essential for healthcare delivery in the modern day, running parallel with public demand for having an accountable and transparent health service (Jupp, 2015). However, it is important that the primary use of this data is not to communicate a return-on-investment, with

this likely misconstruing the usefulness and purpose of ROM for improving client engagement and skills of the practitioner.

7.6.5 Making Greater Use of Client Narrative

Given the recognised limitations of ROM and the risk of over-emphasising the utility of treatment scores, client narrative was considered useful for appraising and validating the implementation of services, in keeping with the research literature and policy (Baddeley, 2014; Coulter et al., 2014; Hamilton et al., 2011; Harding et al., 2011; National Health Service (NHS) Operating Framework 2012/13; Weinstein, 2010). Nevertheless, there were concerns about the response rate in the form of narrative feedback, mainly due to its representativeness and unknown experiences of those who dropout. Similarly, this may reflect other patterns in primary care that make recruitment difficult (Bower et al., 2009). Either way, it was a source a mild distress for practitioners, as this aspect of reflexive monitoring remained out-of-reach.

Clients appeared to relish the opportunity to voice their experiences and be allowed a platform to feedback about their engagement, echoing themes reported by Hamilton et al. (2011). However, this is a very selective group as the recruitment for this project was especially difficult, despite using several avenues for support. Equally, it may suggest that clients are not interested in feeding or reflecting back on their experiences, instead looking to put this time behind them. It may also be due to a lack of knowledge about how to feedback, or not having enough time to do so. Nonetheless, for those recruited in this study, feeding back appeared to provide clients with some closure about their time with a service. On balance, this suggests that providing options for feeding back should be encouraged and well advertised.

7.7 Whole-Systems Thinking

The neoliberal political discourse that underpins much of the IAPT programme's efforts, seemingly favouring a market dialogue over client experience, risks sidestepping the opportunity to create meaningful and compassionate institutions of care, free from judgment and deviation (Barrett, 2009; Rizq, 2013; Middleton, 2014;

Williams, 2015). The fast, high-volume turnover of IAPT services limits the client narrative within a system that obfuscates the wider domains of recovery in favour of an emphasis on quantities (Moloney, 2013; Williams, 2015). Similarly, it may resonate with those who consider the conceptual basis of the programme as being naïve and unrealistic, particularly about the programme's ability to get people back to work, with limited evidence supporting its ability to do so (Cameron et al., 2012; Hashtroudi & Paterson, 2009; Hogarth, 2011). Notably, direct evidence for the programme's return-on-investment is either mixed or limited (De Lusignan et al., 2014; IAPT, 2011; Mukuria et al., 2013; Sreeharan 2013). In light of this, it seems necessary to reconsider the role of IAPT services within an integrated network of other sectors, with each being equally vital.

Highlighting their desire to become more integrated as a service, practitioners sought to clarify their function as a supportive role and part of a greater network that could enable clients in this aspect of their lives. This pattern supports the need to coordinate a whole-systems approach, recognising and incorporating socio-demographic factors along with other sectors. It moves beyond a narrow interpretation that assumes by solely investing in IAPT services this will result in a change in national wellbeing and unemployment rates. Fittingly, this will require addressing cuts which are happening to other sectors that support an individual's wellbeing, such as the social sector (Docherty & Thornicroft, 2015). Adopting this approach risks the costs falling increasingly on the NHS. Layard himself supports a two-pronged approach, involving social and economic policies designed to reduce inequalities found in society (Layard et al., 2006). Moreover, it recognises the need to acknowledge the influence of socio-demographic factors and support communities (Marmot et al., 2010), rather than emphasise an individualistic, reductionist and biomedical understanding about mental health.

7.7.1 Improving Mediating Pathways: Implementation as Integration

The implementation process represents a relational activity, both within and between services. Based on these experiences and together with other related evidence (Knowles et al., 2013), it would seem that one of the biggest obstacles to successful implementation lies in the links and relationships a service has with others. Indeed,

practitioners considered a more integrated service to be the key to improved service provision. It highlights the interconnectedness of health services and the need for whole-systems analysis and collaborative care thinking (Knowles et al., 2013). Evidence corroborates this need to think wider in scope, with cost-savings in other sectors attributed to the implementation of IAPT services (de Lusignan et al., 2011; Mukuria et al., 2012), although the funding allocated between sectors may not always be appropriately spent (Layard et al., 2012). Conversely, there is evidence that highlights increased antidepressant prescribing in England, despite the national implementation of IAPT services (Sreeharan, 2013). In any case, the original proposal behind the programme's inception was to acquire a return-on-investment through a reduction in welfare payments, increased tax receipts, and savings in other healthcare sectors (Layard et al., 2006). It is likely that the key to successfully implementing the IAPT delivery model requires that a service becomes more integrated, extending its inclusion criteria to treat a wider range of clients and provide greater availability for a choice of treatments. Already there are services that have begun to adopt this practice, coining the model as 'IAPT-plus' (Jackson, 2013). However, non-CBT based interventions currently available throughout IAPT services still only represent a minority of all treatments on offer (Dance, 2015). All things considered, the process of integration will require that services integrate and collaborate with other health, occupational and public sectors to achieve more holistic approaches to care.

The pathways leading up to accessing an IAPT service deserve special consideration. For clients, these stages were felt to be especially isolating and confusing, compounded by a lack of awareness and negative expectations about services. Likewise, accessing treatment required a great deal of personal determination and courage. This trend possibly reflects the neoliberal context and philosophy underpinning primary care mental health services, which emphasise client autonomy and self-reliance (DH, 2011a). Clients felt stuck and isolated in between services, with much of their prior experience characterised by a process of finding the right fit. While this might help explain the high level of client disengagement during the initial stages (HSCIC, 2014a, 2014b; Griffiths & Steen, 2013a; Richards & Borglin, 2011; RCP, 2013) it does also suggest that client knowledge about the mediating pathways and availability of services is lacking. Ensuring there is clear

communication during prolonged waiting times was considered vital for the basis of feeling less sensitive and vulnerable, a finding that is similarly reported elsewhere (Easby, 2010; Hamilton et al., 2011; Savage et al., 2015; RCP, 2013). Without this, clients may feel isolated and overlooked (Byng et al., 2011; Hamilton et al., 2011; RCP, 2013), as though the service was uninterested in them, leading them to ruminate. This repercussion further supports the need to strengthen mediating pathways into and out of services, making use of effective communication techniques to offset feelings of anxiety and uncertainty. Similarly, a client's history of CMHPs is not routinely collected in IAPT services (Buckman, 2014), although the findings presented here suggest this will need reconsidering. Above all, it is fundamental that services recognise a client's journey preceding and beyond their engagement by making their role and facilities as visible and accessible as possible.

7.7.2 Engaging with GPs

The GP was integral to both the experiences of clients and practitioners, with each greatly admiring and valuing their role in the management and support of clients. For practitioners, engaging with GPs was considered to be an essential component of the implementation process, something that the literature suggests is a crucial practice (Byng & Gask, 2009; Gyani et al., 2012; Stern et al., 2015). Likewise, Layard et al. (2012) propose incorporating a mental health module into GP training to help overcome potential barriers at this stage. This proposal likely reflects the need to help GPs overcome a poor awareness about IAPT services (Gyani et al., 2012; RCP, 2013) given that, if inappropriate, their referral practices can lead to problems in provision (see The Referral Practices of Others p.235).

Although greatly admiring and cherishing their GP, the perceived pressures on them from the perspective of clients appeared to dissuade their desire to consult with them. The solution to this may be the use of a self-referral pathway, to enhance access, while also overcoming language, ethnic and cultural barriers (Brown et al., 2014; Clark et al., 2009; Green et al., 2013; Lovell et al., 2014). This could relieve the pressures on GPs and feelings of guilt among clients. Nevertheless, GPs are best placed to inform and engage clients about these types of services (Layard et al., 2012). Equally, theirs' and other practitioners' advocacy can be useful for improving

a client's initial receptiveness towards treatment (Bennett-Levy et al., 2010; Marks & Cavanagh, 2009; Richards et al., 2006; Richardson et al., 2010). GPs also have a vital role to play in boosting service awareness and determining treatment. Comparatively, this resonates with the responses of clients included in this research who proposed greater training and engagement with GPs about services, so that they are able to relay information more readily (Gyani et al., 2012; Layard et al., 2012). Equally, it is necessary to reconsider the pressures on GPs and how this is conveyed to the public, perhaps developing a way to enhance a GP's time with their clients. Providing added resource for GPs might improve service efficiency and client experience when accessing an IAPT service, further justifying the need for strong GP engagement. Therefore, this evidence provides a persuasive argument for the need to engage with GPs more in mental health, especially regarding IAPT services and the significances of self-referral.

7.7.3 Thinking Beyond the Boundaries of the Service

Evidence indicates that awareness of services can be poor (Hamilton et al., 2011; Savage et al., 2015; RCP, 2013), with the findings reported here in support of this. Aside from engaging with the GP, there appears to be a need for greater community engagement in publicising services, also likely having implications about the use of a self-referral pathway. Furthermore, it may help overcome barriers in help-seeking among clients, which can often be poor (Barnes, 2011; Anderson & Brownlie, 2011; Cameron et al., 2012; Evans-Lacko et al., 2013; McManus et al., 2009; Vogel et al., 2009). Accordingly, making services more visible and accessible will likely combat the difficult and uncertain transition into services. Therefore, although not immediately obvious, implementation and service delivery also encompasses the need to publicise and engage in the community.

During and soon after leaving a service, clients spoke of being able to identify traits in others who may be avoiding having to confront or attempt to deal with their issues. Considering that service advocacy by others was a notable motivator during the early stages (Bennett-Levy et al., 2010; Marks & Cavanagh, 2009; Richards et al., 2006; Richardson et al., 2010), there might be a cumulative benefit of people gaining access to IAPT services. This effect, although not easily measurable, bolsters

the therapeutic benefit of IAPT service provision, as well as providing a helpful narrative for the benefits of engagement beyond treatment discharge.

Involving the family during treatment may also be useful although this can be difficult in light of therapist attitude and limited accommodation (Shepherd, 2014). As can be gathered from the findings, the decision to engage was not necessarily an individual endeavour, but a social one, stemming from feelings of guilt towards others and self-blame. Sources of guilt as a motivating factor have been reported elsewhere, either through not retaining employment (Cameron et al., 2012) or perceiving oneself to be a burden on others (Brazier & Connell, 2014). However, the flipside of this is when others recommend a service, it can potentially serve as a motivational tool, possibly overcoming negative preconceptions and self-blame. On balance, the involvement of the family and others could prove useful in overcoming the impacts of an individualistic approach, but this will need to be judged on a case-by-case basis to determine its feasibility.

The newfound knowledge about services provided participants with a safe base from which to return. No clients actually felt the need to return but felt thankful for the fact that they could if needed. This knowledge enabled them to feel more confident in their life beyond therapy, suggesting praise should be given regarding the openness and accessibility of services. Additionally, it may have something to do with the benefits of using a self-referral pathway (Brown et al., 2010; Green et al., 2013). That said, with regards to follow-up, one client in particular (Sarah) felt disheartened, indicating that she longed to be contacted again and thus feel more cared for and less like she was forgotten. Although clients were recently out of therapy (up to one month), none had agreed on a follow-up procedure with their therapist. Other evidence reports similar themes, suggesting that the use of a follow-up conveys the service as more caring, interested and approachable (Hamilton et al., 2011; RCP, 2013). The implementation of a follow-up is not always feasible or routinely used in IAPT services (Byng et al., 2011; Glover et al., 2010; Hamilton et al., 2011), with a notable degree of dropout for those who are followed-up (Clark et al., 2009; Mukuria et al., 2012). Subsequently, it may reflect the high-volume, fast access throughput that characterises IAPT provision, meaning that services are less incentivised to re-contact clients. Similarly, the use of a self-referral pathway may be

used to justify there being less of a need to implement a follow-up procedure. Regardless, the benefits for a follow-up may help clients feel supported, boosting their admiration about a service and their treatment. It will also have the added benefit of confirming whether engaging with IAPT services leads to sustainable outcomes.

7.8 Limitations

Recognising and acknowledging the strengths and limitations of research is vital for ensuring the integrity, applicability and generalisability of its principal findings and conclusions (Holloway, 2008; Robson, 2011). Given the nature of this inquiry, the representativeness of the data is limited, both by the small and selective sample recruited, and by the subjective nature of participant responses and interpretative analysis. It is important to recognise that different findings could have been discovered and analysed using a different participant group or indeed a different researcher.

Accordingly, this has particular relevance for the client group who were predominantly White British (with the exception of Maria), or female, (with the exception of Trevor) (see Appendix 11.6.2). Clearly, this is not representative of the client population attending IAPT services. By interviewing a more diverse group this might have introduced several additional elements to the study, including a cultural and gender component. Consequently, this might have provided some insight into the different ways that distress and recovery are conceptualised across different cultures, and whether mental health services are inherently 'feminised' and therefore discouraging to men (Morison, Trigeorgis & John 2014). However, in conducting the recruitment process I closely followed the guidance and rationale described by Smith et al. (2013) who recommends smaller sample sizes who are purposively selected to enhance the quality, richness and depth of the data collected. Equally, this research compares well with previous studies in this area having attempted to also recruit non-English native speakers.

Comparatively, another limitation of purposively selected recruitment methods is that it relies on the researcher's judgment about who is best suited to providing data

in light of the research aims. To clarify, the sample chosen were selected on the basis of their experiences and expertise, and in consultation with my academic supervisors and other healthcare professionals. However, the final decision about who these groups should be was based on my own judgments and this could have risked failing to recruit a more suitable participant group providing greater insight.

The recruitment process for inviting clients to participate was particularly difficult, reflecting wider trends in primary care research (Bower et al., 2009). Clients may have been more willing to pursue participation due to their positive experiences (Bower et al., 2009), or due to practitioners more likely to pass along information to those they had successfully treated. Consequently, this may also have a bearing on the findings regarding the use of over-the-phone techniques for assessment and therapy. It may be that clients receiving treatment over-the-phone were less likely to receive information about this research, or be typically less willing to participate, misrepresenting this finding. That said, the recruitment process did draw upon multiple avenues for advertising so it is possible that a proportion of these clients were contacted.

As with any interviewing techniques the responses obtained are potentially limited by recall bias (Giorgi & Giorgi, 2003), participant agenda (Flick, 2004), socially acceptable and self-censoring narratives (Dyson & Brown, 2006), and demand characteristics (Shedler et al., 1993). One issue which became apparent during the interviewing stage was discovering how much of a political and polemic issue the IAPT programme is, potentially influencing the nature of responses from certain participants (see also Personal Reflections p.274-277). As with any self-reporting data, the impact of socially acceptable and self-censoring narratives presents a concern about the utility and accuracy of the data. How each of these factors influenced each of the participants could ultimately have impacted on the overall themes generated. Nevertheless, these factors were recognised from the outset, having already been given careful consideration in the critique and choice of the methodological approach (see Methodology p.83-122). Subsequently, many techniques were used to reduce the impact of these, such as the use of a reflexive diary and bracketing techniques. Similarly, participants were reminded that honest

answers were of greater use overall and steps were taken to protect the identity of participants, potentially enhancing their desire to share their experiences accurately.

Another key point is that this study captured participant experiences through the use of language and narrative. In particular, social constructionism, which informs this qualitative study, has been criticised for its emphasis on language (Robson, 2011; Savin-Baden & Major, 2013). Accordingly, there are inevitably going to be challenges in the variance and validity in articulating experience through language with certain aspects difficult to access through dialogue alone.

This thesis involved a broad inquiry about the implementation of IAPT services across a range of settings. As such, all participants in the client group had engaged with different forms of therapy and at different stages in the delivery model. Certainly, this will have led to different experiences about the provision of therapy, due to a variation in frequency and brevity concerning the therapeutic format. Nevertheless, the focus of the inquiry was to gain insight into how the delivery model may influence their overall experiences by exploring the processes of access, engagement and outcome. Therefore, the impact of this on the aims and objectives of the thesis were not considered at risk.

Another possible limitation in the use of semi-structured interviewing is the choice of questioning. The use of qualitative techniques is beneficial as it enables the research to explore complex processes in richer detail. However, there is still a need to formulate a series of questions to focus and gain insight into an area of interest. In considering this, the questions chosen were informed by the conceptual and theoretical frameworks of the patient pathway and NPT (DH, 2007; May & Finch, 2009). A consequence of this could be that the resulting themes are determined more by the frameworks rather than being a true reflection of a participant's experience. In particular, the master theme and its subordinate themes for 'A Personal Journey: From Discovery to Advocacy' in the client group are reminiscent of the patient pathway around the stages of access, engagement and outcome. Nevertheless, this decision ultimately represented a trade-off, balancing an ability to explore a participant's experience while remaining focused enough on achieving the research

aims. Similarly, the questions chosen were broad and open to elicit discussion and any unique emerging findings were explored during the interview.

As already discussed in the methodology chapter, these points relate to the concept of validity in qualitative research. To repeat, qualitative approaches are more concerned with issues around persuasion and trustworthiness (Robson, 2011; Sandelowski, 1993). For this reason, the use of IPA is valuable given its transparent and auditable nature (see Appendix 11.11.1 & 11.11.2) with steps also taken to enhance the trustworthiness of the findings, including bracketing techniques, negative case analysis, triangulation, and peer examination (Savin-Baden & Major, 2013). Crucially, it was important to ensure that what I was presenting and discussing was firmly grounded in the data and supported by the participants' own words. Accordingly, the process of persuasion and issue of trustworthiness is made explicit to the reader.

On balance, while these limitations do not invalidate the overall findings and discussion, it is necessary to take them into account when considering the implications and conclusions of this thesis. Similarly, it is important to recognise that this research makes no claims about the generalisability of its findings. Rather, it is intended to provide rich, in-depth data to help inform and reflect on the implementation process and operation of services included here.

7.9 Summary

The experiences of implementing the IAPT delivery model appears to be greatly influenced by the need to boost throughput and quantity, possibly at the cost of quality. Given that the early implementation process was particularly rushed, there appears to be an apparent urgency in top-down pressures from central government seeking a return-on-investment. Moreover, the IAPT delivery model is useful for implementation as it can adapt and respond to the local area need, with the use of ROM to test ongoing innovation. Equally, the use of ROM might be useful for encouraging and enabling the therapeutic encounter and ongoing service engagement. Conversely, the pursuit of more order and control in IAPT services, via the use of an uncertain diagnostic categorisation system, may lead to problems in accommodating those clients who do not fit the model or fall through gaps in services. The key to successful implementation appears to be integration, likely requiring a whole-systems based approach that considers the mediating pathways into and out of services.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

8 Conclusion

The Improving Access to Psychological Therapies (IAPT) programme is currently the main vehicle for treatment in the provision of psychological therapies in primary care (Department of Health (DH), 2011a). Since its announcement in 2007, it has achieved a full-scale national rollout, employing approximately 5,561 people (Whole Time Equivalent) (Dance, 2015). Additionally, nearly one million people are being referred to services annually, with around 40% 'finishing a course of treatment', of which 45% 'move to recovery' (Health and Social Care Information Centre (HSCIC), 2014a). However, these figures mask huge variation in outcome scores and client attrition, not to mention the observed gap in treatment efficacy from research trials into clinical settings (Glover et al., 2010; HSCIC, 2014a, 2014b). Equally, there are many concerns regarding the variable nature of service provision between areas (Glover et al., 2010; Richards et al., 2012), including guidelines not being followed (Delgadillo et al., 2013; Gyani et al., 2011; Royal College of Psychiatrists (RCP), 2013), and a high rate of client disengagement early on (Glover et al., 2010; Griffiths & Steen, 2013a; Richards & Borglin, 2011). There are some who criticise the IAPT programme's conceptual basis and emphasis on high-volume, fast access throughput (Barrett, 2009; Cooper, 2009; Loewenthal, 2015; Rizq, 2012a, 2013; Scanlon & Adlam, 2010; Marziller & Hall, 2009; Scanlon & Adlam, 2013; Pietroni et al., 2012; Walker, 2012; Williams, 2015), arguing that the approach is naïve and idealistic.

The characteristics of the IAPT delivery model are unique as it aligns more closely with a research trial by standardising its treatments (via supervision, training, and treatment manuals) and incoming clients (via diagnoses and inclusion/exclusion criteria), to maximise and improve outcomes. There have been various research studies, mainly quantitative, that have sought to evaluate the progress, impact and overall effectiveness of the initiative. The review of the literature revealed there to be little in the way of qualitative research for exploring the process and experiences involved in implementing services. Instead, most efforts have tended to rely on quantitative outcomes and cross-sectional observational studies. Ultimately, this limits the understanding regarding the dynamic and nonlinear processes that

characterise implementation (Stetler et al., 2006). Consequently, it fails to capture what factors are influential in the successful uptake and integration of the IAPT delivery model, and by extension, evidence-based practice. Therefore, the basis of this thesis was to understand these processes by exploring the experiences and behaviours of practitioners delivering and implementing services. Accordingly, it also investigated which factors impact on client experiences when engaging with the model.

8.1 Addressing the Research Questions

What factors influence the successful uptake and integration of the IAPT delivery model?

The IAPT delivery model represents a clear and systematic approach to ensuring that individuals have equitable and timely access to Evidence-Based Psychotherapeutic Interventions (EBPIs). However, it is this approach that requires that practitioners implement greater control over who is entering a service. Improving service effectiveness and therefore, the successful uptake of the programme, means that the provision of treatment needs to focus solely on clients who fit the model and are more motivated and committed to engage. Meanwhile, difficulties lie in the fact that particular clients may not necessarily fit this model, either due to poor referral practices, being in an isolated setting, poor intermediary pathways between services, or issues surrounding the use of a diagnostic categorisation system for labelling Common Mental Health Problems (CMHPs). As a consequence, the delivery model runs the risk of favouring those who are more likely to move to recovery or fit with a biomedical understanding of mental health, thus constructing a false reality about service effectiveness (Callan & Fry, 2012; Griffiths & Steen, 2013a; Richards & Borglin, 2011; Rizq, 2012a). In response, referral and assessment practices are progressively being transformed so that clients require greater autonomy and self-reliance to access services, thus allowing practitioners to personally assess them against these criteria. In reality, the high-volume, fast access throughput of the programme means that increasingly, the suitable exploration of a client's issues is potentially being diminished, therefore likely impacting on service efficiency and its overall effectiveness.

In light of the findings and research literature, the implementation of the IAPT delivery model appears to be heavily influenced by the need to increase client throughput. The over-arching pressures in targets require that practitioners treat as many people as possible, leading to a greater emphasis on delivering low-intensity treatment, or using over-the-phone techniques for assessment and therapy. Equally, the urgency in early implementation and oversight regarding the need to integrate the service into a pre-existing context meant sacrificing certain aspects of provision. Therefore, an important factor influencing the implementation of services revolves around the macro-level pressures which emphasise an increased access and throughput of clients, perhaps even at a cost of quality.

As a whole, it seems that the key to successful implementation is developing ways to integrate a service, likely requiring a whole-systems based approach that considers the mediating pathways into and out of services. These efforts were beneficial for clarifying entry criteria and boosting service awareness. It appears that greater engagement in the community and cooperation with other sectors is warranted so as to improve holistic care. Accordingly, this will likely overcome the issues of assuming that solely investing in IAPT services will improve the nation's mental health and employment standing. One relationship of particular importance was that of the General Practitioner (GP). Certainly, the GP has a vital role to play in coordinating client care between sectors and improving service awareness; therefore, their engagement and collaboration are critical.

Moreover, seeking integration meant being mindful and responsive to geographical and budgetary constraints. The utility of a stepped-care model permitted practitioners to be able to adapt their approach to become more locally relevant and capable of meeting the changes in demands on them. However, the context in which services were located heavily influenced the implementation process with several efforts undertaken to overcome poor links between other sectors. Integration also involved the need to assimilate a pre-existing workforce about the new ways of working. This was likely due to a vast shift in service provision which now increasingly emphasises fast access and throughput.

Lastly, the current emphasis on Routine Outcome Monitoring (ROM) had some notable benefits in its use for the implementation and operation of services. One principal advantage was its usefulness for gauging the impact of practice innovations, thus providing practitioners with more instantaneous feedback. Other benefits include boosting treatment fidelity (Shimokawa et al., 2010), correcting therapist blind-sidedness (Lambert, 2010; MacDonald & Mellor-Clark, 2014; Shimokawa et al., 2010), encouraging client engagement, enhancing treatment effectiveness (Boswell et al., 2015; Knaup et al., 2009), and importantly providing the programme with evidence about its effectiveness for gaining ongoing investment (McHugh & Barlow, 2010). Equally important was providing a platform for reflective practice and planning opportunities to support organisational refinement in light of these outcomes.

How do those delivering services experience the implementation process?

Overall, the experiences of those practitioners interviewed expressed positivity, admiration and pride in their work, seemingly due to them feeling part of something worthwhile and unprecedented. This feeling appeared to act as an emotional charge, motivating them throughout their ongoing efforts. Consequently, this seemed to contain and reduce the impact of emotional exhaustion from trying to accommodate to meeting challenging targets, with each feeling duty bound to endure these difficulties. Under these circumstances, it could be argued that this represents complicit behaviour, with each practitioner failing to voice any concerns about potentially unrealistic and perverse targeting in the interest of securing continued funding (Rizq, 2012a). Therefore, their skills and judgment about the care and provision of treatment are seemingly reduced in favour of functional, service and operational gains.

There were ongoing pressures on practitioners delivering services who attempted to balance these demands in line with their ethical and compassionate role as a caring practitioner. Consequently, the implementation process was essentially a balancing act between ideologies of quantity versus quality, business versus clinical, and functional versus compassionate. Their role as an intermediary led to tensions in care with each resisting the perverse incentives inherent in the programme, while also

balancing the needs of the many with the needs of the individual. Equally, it was valuable for practitioners to construct service effectiveness by using client narrative so as to move beyond the narrow, technical and problematic definitions regarding recovery in IAPT services. For this reason, it is necessary to consider what is meant by referring solely to treatment outcomes and importantly, what it represents, in order to avoid distorting the reality of things.

The growing pressures on services to increase throughput, together with the premise of self-reliance among those suffering from a CMHP, has the potential to stimulate a growing disconnect between practitioner and client, with the latter perceived as a utility for the service, reducing a platform for relatedness and dependency (Rizq, 2012a). Furthermore, the perceived urgency during implementation, particularly in the early stages, in conjunction with a failure to recognise the influence of service context and integration, resulted in a number stressful and demanding experiences. Consequently, this was due to several unrealistic expectations, which could potentially grow as services are increasingly being asked to do more with less resource (Docherty & Thornicroft, 2015; Layard et al., 2012).

Practitioners made sense of their decisions by attempting to derive maximum benefit from finite resources in light of service and geographical constraints, as well as staff availability. One of the greatest difficulties for practitioners was having to integrate an old service with a new one, something that required transforming organisational culture. Involving the staff in the design and development of services was considered to be particularly valuable, overcoming resistance and increasing the autonomy of the workforce. The implementation process and operation of services represented a scene of immense and constant change. Accordingly, the use and value of having a reflective space were beneficial for determining the effectiveness of ongoing organisational development. However, given the demands of practitioners and service constraints, particularly regarding accommodation, this represented an ongoing struggle, supporting the need to acknowledge these aspects of provision when imposing new targets and changes in delivery.

What factors are influential in the experiences of clients during service engagement?

Those engaging with the IAPT delivery model underwent a transformation, typified by a series of pivotal moments. The mediating pathways into and out of services created uncertainty in clients, with the stages directly preceding access considered to be the most vulnerable and confusing. It seemed that each client was engaged in a process of finding the right fit, continually searching for meaning and understanding about their distress, while also judging whether the treatment offered was right for them. For this reason, the initial stages garnered a great deal of attention in the experiences of clients. In particular, due to the sensitivity felt at this time, certain practices implemented by the service made this transition difficult. To gain access to treatment, this group had to push beyond boundaries, both within themselves and during the assessment. The process of finding the right fit and feeling overwhelmed in the early stages may go some way to explaining the notably high rate of client disengagement during this period (HSCIC, 2014a, 2014b; RCP, 2013; Richards & Borglin, 2011). Confronting difficult questions and feeling isolated by poor communication practices meant that clients required a great deal of determination and courage to be able to access treatment. Thus, this helps to characterise the culture of self-reliance and presumed autonomy in clients accessing services, likely influenced by a neoliberal context.

The efforts undertaken to preserve the therapeutic relationship was considered beneficial to supporting ongoing engagement. The therapist went from being essentially a stranger to a close confidant, further influencing their dynamic relationship with a service. During the initial stages, their input was greatly needed, however as the therapy wore on, clients spoke of feeling more enabled to take control over the course of their treatment. Conversely, the client group considered the use of over-the-phone techniques as potentially threatening the therapeutic relationship, stemming from feelings of isolation and suspicion. Feeling a connection in therapy was useful for gaining insight about themselves and for validating progress. Equally, the use of ROM appeared useful during engagement for validating progress, similar to comments made by the practitioner group, suggesting an additional therapeutic benefit regarding their use. Nevertheless, these scores may not always reflect how a client understands their own distress and meaning of recovery,

supporting the need for more open dialogue. Likewise, this open dialogue should invite clients to be more inquisitive and speak of their concerns regarding the course of treatment. This approach could prove invaluable as some clients may remain quite guarded during their treatment, and therefore, unwilling to voice any concerns for fear of causing offence to their therapist.

As already mentioned, the early stages were a particularly difficult time for clients. One of the reasons for this seemed to be due to a lack of awareness about services that ultimately led to a number of negative preconceptions. Navigating these stages in between sectors was reportedly challenging. Many spoke of the role of their GP being crucial during this stage, but felt somewhat abandoned, either due to the perceived pressures on these professionals, or having to use a self-referral pathway, despite having already consulted with them. Building confidence in the intervention appears to be equally important, with the role of others, particularly the family, acting as a source of encouragement, either through a recommendation or guilt felt towards them. The role and location of the service provided clients with an adequate space to take themselves away from stressful environments, even perceiving the journey itself as an achievement. As such, it is important to recognise that service engagement is not necessarily an individual endeavour, but a multi-faceted, complex and social process. Given that the advocacy of others was a powerful motivational tool, and that clients ending treatment were likely to recommend it to others, this highlights a cumulative benefit of people engaging with IAPT services.

8.2 Recommendations for Practice

In response to the findings of this thesis, there emerged a number of key points that are now addressed and presented as recommendations for practice:

1. Although the implications for improving access to services are well grounded, it is imperative that these efforts do not detract from the delivery of compassionate care, thus refraining from a system that emphasises a narrow approach, quicker throughput and greater self-reliance, impacting on the attachment towards and supporting incoming clients.

2. Similarly, efforts should be made to encourage a wider and more holistic understanding of client recovery, avoiding an over-reliance on limited, brief symptom-based outcome measures for the basis of determining service effectiveness. Instead, it is important to set outcomes in a context of integrated strategies that address the wider determinants of mental wellbeing, closing gaps in-between services and focusing on a more inclusive delivery model, rather than an exclusive one.
3. The programme should create and promote a platform for critical dialogue and reflexive monitoring that provides adequate space and time to reflect on the changes in practice, acknowledging the need for integration, cultural shifts in the workforce, and the impact of local determination, thus circumventing unrealistic expectations.
4. Extra resource should be allocated to supporting the enhancement of mediating pathways into and out of services, particularly for engaging with GPs and communities, and importantly, for the implementation of self-referral pathways.
5. To avoid feelings of isolation and uncertainty during times of waiting, communication is of particular importance. Equally, there should be added focus on getting the early stages right when engaging with clients.
6. An open-dialogue should be encouraged, inviting clients to question the type of language and approach used, accepting that clients will likely draw upon a rich, unique and varied conceptualisation about their condition, hence overcoming any possible confusion, negative preconceptions and discomfort they may have.
7. As a service, it is necessary to recognise the dynamic and changing relationship a client has with their service, realising that therapist input is likely to change as a client becomes more enabled.
8. It is important to discover ways that prioritise the development of high-quality relationships between the practitioner and client, while also being mindful of the use of over-the-phone techniques for forming and maintaining this relationship and affinity felt towards the service.

8.3 Recommendations for Further Research

While this thesis presents new knowledge for the implementation of IAPT services and the impact of current legislation on psychotherapeutic provision, it also generates other interesting avenues for research to pursue:

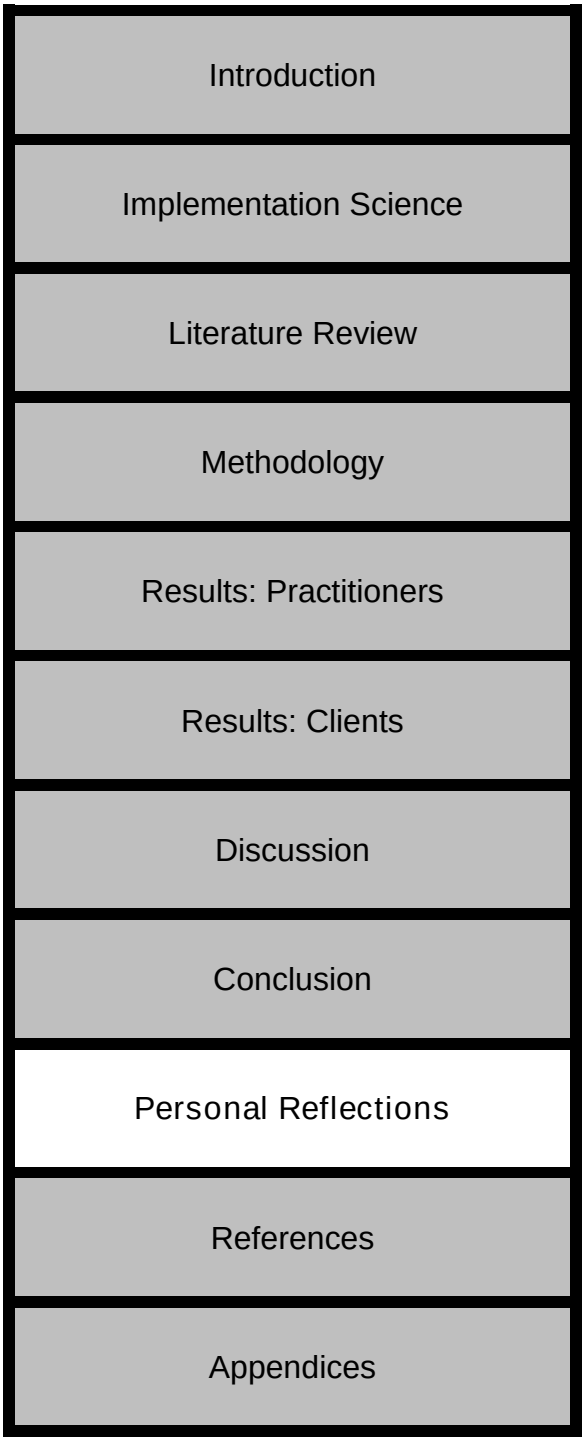
1. Considering the limitation regarding the generalisability of these data, it would be useful to assess whether the findings and themes resonate with other practitioners and clients in this area. Accordingly, it would be feasible to conduct a survey to analyse the level of agreement and types of responses towards these findings and in so doing, potentially revise and update the recommendations. A short survey questionnaire could be administered remotely, either via the post or online, to a large number of individuals, and at a relatively cost-effective means.
2. In consideration of the challenges discussed relating to the concerns about using a diagnostic-based approach in IAPT services, it would be useful to explore alternative models for profiling clients accessing and engaging with treatment. These approaches could incorporate multiple social factors to assess how they impact on engagement and rates of recovery. Notably, there is already work underway to alert practitioners about cases at risk of poor outcomes by considering these characteristics (Delgadillo et al., 2014a, 2014b). Such an approach would likely enhance recovery rates by identifying which factors lead to poorer outcomes and how best to address these.
3. By the same token, the concept of language and identity appeared to be particularly important to clients, with certain phrases and definitions discussed at length regarding a conflict between perceived experiences and use of labelling. It would be interesting to assess how a client engaging with IAPT services came to understand the nature of their mental health, including the concepts of recovery, and how this might have changed as a result of their engagement.
4. The findings reveal the important role of the assessment session in the negotiation and provision for a course of treatment, with its purpose seemingly preserving service effectiveness. However, client experience during these stages was characterised by various negative emotions, including

increased sensitivity and uncertainty. It is not yet clear how crucial the role of assessment is and whether it is more advantageous to emphasise quicker access to therapy or encourage more in-depth dialogue, possibly educating and making use of other therapeutic techniques or options within the session. Moreover, the format for this session is also worth investigating given the potential strengths and limitations for its conduct over-the-phone.

5. It will be worthwhile extending one of the central arguments made in the discussion chapter to a larger-scale, pluralistic, mixed-methods project that takes a systemic approach to more effectively capture the processes throughout the whole-system. This would involve the participation of multiple sectors, including GPs, commissioners, secondary care services, service managers, psychological therapists, counsellors, administrators, and the inclusion of a client's family where feasible. Such a project would require investigating the clinical, political, economical and environmental factors influencing the implementation and operation of services.
6. One factor that is central to the organisation of IAPT services is the stepped-care model, with a general trend towards its increasing use and emphasis on low-intensity treatments and faster access, as suggested above. However, given the added precedence and value of the therapeutic relationship, it is not clear how clients experience the stepping-up process in IAPT services and what effects this might have on the therapeutic relationship or their attachment to a service. The evidence that does exist is limited (Gellatly, 2011) with clients (n=14) reporting a general misunderstanding about the process of referral and discharge, and a general mismatch between what a service judges to be recovered versus what the client thinks. Equally, with the newly increasing emphasis on low-intensity treatment and pressures on services to enhance throughput, further investigation is needed. The delivery model was developed with an emphasis on service provision and efficiency and is therefore not entirely driven by client needs. Moreover, it forgoes the potentially painful process of requesting to be stepped-up and engaging with another therapist. In any case, understanding these experiences may help to boost the process of stepped-care and improve its acceptability among clients.

8.4 Overall Conclusion

The implementation and dissemination of IAPT services have undoubtedly been worthwhile for the provision of psychological therapies in primary care, having treated a substantial number of clients, of whom would not have been able to access these interventions previously (HSCIC, 2014a, 2014b; IAPT, 2012). From the perspective of implementation, the programme's clear policy, service organisation and general direction have enabled a more robust application of research knowledge to a real-world clinical setting. The use of ROM has also served to provide a more up-to-date reflexive component, affording those practitioners and national governing bodies the ability to reflect back on service provision and innovation. The mediating pathways into and out of a service represent a potential obstacle to integrating care and enhancing service awareness. Moreover, the early stages of client engagement symbolise an especially significant period, with services trying to gauge whether they can treat a client given their condition and complexity. Comparatively, clients in these stages may feel uncertain and be engaged in a process of finding the right fit. Nevertheless, there may be certain unintended consequences associated with implementing IAPT services, this being due to the influence of target-driven practice and its underlying conceptual basis. There is a risk that relying on brief, symptom-based outcome measures for the evaluation of services could distort care, favouring incoming clients who are judged to fit a particular model, or who are more likely to show an improvement on these measures. The significance of this qualitative study is that it gives rich, detailed insight into the dynamic and nonlinear processes involved in implementation. The experiences associated with implementing and receiving an IAPT service were often characterised by a process of responding to and coping with multiple social and demographic factors. Therefore, it is important to recognise their influence on the provision and evaluation of services, preferably adopting a wider scope, and acknowledging those who may not necessarily be helped by the IAPT delivery model, thus developing a more holistic and rounded approach to care.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

9 Personal Reflections

Reflective practice is a deliberate process of continuous learning that encourages the development of insight through paying close and critical attention to our everyday actions, comparing the intended purpose of an action with its actual outcome (Bolton, 2014). It involves not only reflecting back on past experiences but taking a conscious and careful look at our feelings, actions and the responses that went with it. It is thought to act as a useful tool for personal and professional development as it allows individuals to reflect, evaluate and refine future planning and work-life activities. Although there are many different models available to assist professionals in their reflective practice (Gibb, 1988; Rolfe, Freshwater & Jasper, 2001; Schön, 1987), the general approach is to take a step back and critically engage and develop a resolution strategy that is not reactive, but constructive (Bolton, 2014). Although reflective practice as a tool for improving outcomes in professionals is not proven, it appears that its use can serve several functions, including enabling an individual to uncover meaning from complex experiences; this being useful for learning (Mann, Gordon & MacLeod, 2009). For this reason, I consider its use to be a helpful tool in attempting to critique more objectively my research so that I can learn to grow, not only as an academic but also as an individual.

For Bolton (2014, p.115) “Reflective writing is the reflective process”. Using Interpretative Phenomenological Analysis (IPA), the analyst is encouraged to keep a record of the analytical process using a reflexive research diary, so that it is possible to establish a greater awareness of emerging interpretations on the nature and content of data (Brocki & Wearden, 2006; Smith et al., 2013). Taking it broader than this, I was encouraged early on to write a weekly journal diary to assist me in reflecting on the theoretical and practical aspects of my investigation, including the literature I was reading and any emerging insight. Although the quality of journal writing can vary, it is important that the process is done effectively, with this requiring a safe, exploratory, engaging and honest activity (Finlay, 2008). On reflection, I feel this method has served me greatly, assisting my continual learning by enhancing a deeper reflective process and allowing me to consider several distinct theoretical perspectives.

On reflecting back, certain situations made the completion of this research project problematic. The most prominent issue was convincing the Improving Access to Psychological Therapies (IAPT) services to participate. Some were enthusiastic and receptive about contributing while others were notably reluctant. The reason being was due to my association with a unit that was considered in many ways to be 'anti-IAPT'. In hindsight, I believe this was because of a couple of papers a colleague and I had published, which attempted to set the outcomes of the IAPT programme in a broader context of clients accessing services (Griffiths & Steen, 2013a, 2013b). Similarly, the unit's director from which I work, who is also my principal academic supervisor, had been previously quite vocal about his concerns regarding the IAPT programme (Pietroni et al., 2012). In spite of my intention to act as an independent and objective researcher, my background made it difficult to convince others of my genuine intentions. Fortunately, I was able to convince the IAPT services, but it was a steep learning curve for me, given the anxieties and struggles that went along with it. In my naivety, I had considered the research process to be pure, free from political interest, which seemingly could not be further from the truth when it comes to studying or critiquing the IAPT programme. It is important now that I attempt to be mindful of another person's position when seeking their participation and collaboration. I was apprehensive that these interviews would be challenging; however, I considered each one to be particularly enjoyable, and I feel indebted to each participant for their willingness to contribute. Looking forward, I hope to move beyond an 'anti-IAPT' label as I hope in this thesis, and in any future work that I am a part of, I am clear that I am not against the IAPT programme, as I greatly admire all that it has done and continues to do.

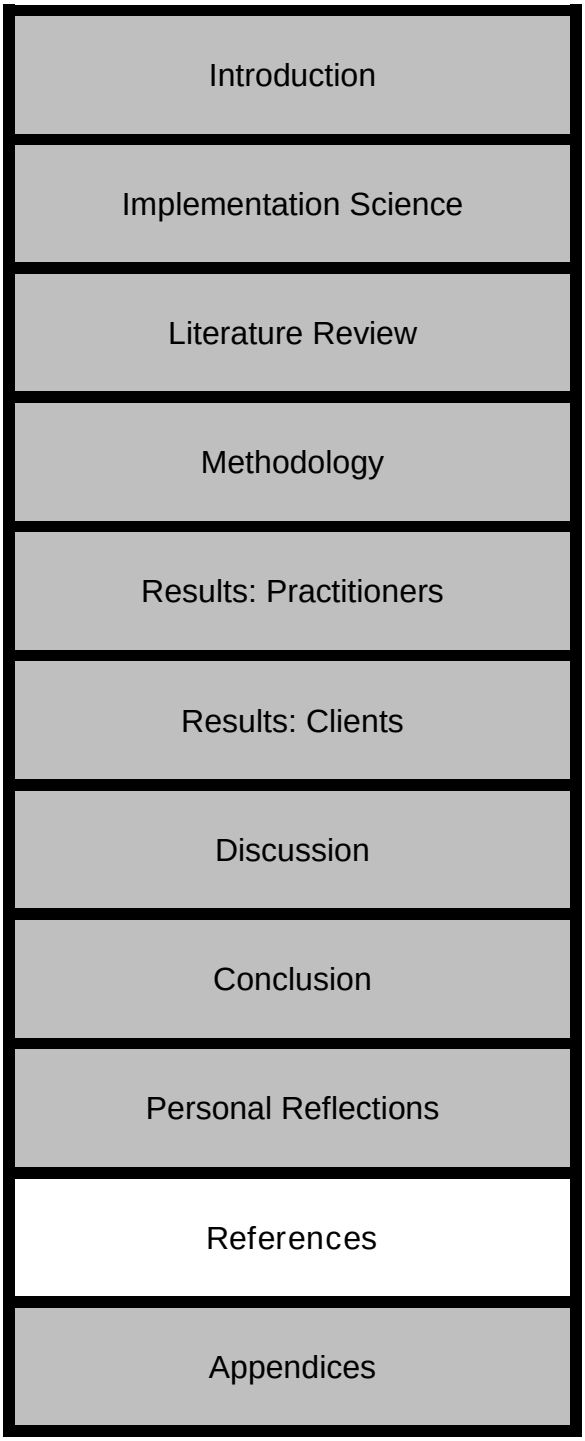
Another serious difficulty I faced was in obtaining ethical approval from the National Health Service (NHS) regarding interviewing clients engaging with the programme. Despite my consultation with an independent advocacy service, approval from one ethical body already, and consent from the IAPT services to conduct this research, I felt there was a general misunderstanding about who I was interviewing within the ethics committee. Originally I had submitted an application via an electronic route, but after two failed attempts I attended an in-person review meeting. It seemed clear to me that the concerns lay in the fact that mental healthcare is still remarkably

misunderstood, with the committee presuming I would be interviewing people who were severely disturbed or incapacitated. Fortunately, I was able to challenge these misconceptions given that Common Mental Health Problems (CMHPs) are, by definition, common in the population, and most importantly that these people have a voice. It was interesting for me to observe how the many misunderstandings surrounding mental healthcare can permeate at various levels. I understand that the committee had the best of intentions, concerned for the involvement of vulnerable individuals. In any case, I consider it to be a worthwhile and valuable experience, realising now that my oversight regarding this issue cost me precious time; therefore, I intend for it not to be replicated.

I consider the course of research to be a slow, trying and exhausting process, but one that is incredibly rewarding. Already, the findings of this project are currently being consulted and applied in several other projects and research studies about service quality improvement. These include projects that seek to develop voluntary sector services by engaging with data, improving provision in a mental health service, and exploring ways to improve the health and wellbeing of NHS staff. These all share in common the desire to engage in more action-based research, prioritising a practice-based evidence approach, and seeking to discover how change can occur by bridging the "chasm" that characterises the research to clinical gap (Institute of Medicine, 2001, p.1). I remember being initially shocked by the fact that in the last 40 years, evidence has shown little change in the effectiveness of psychotherapy (Miller et al., 2014), suggesting that the current path to knowledge may be stagnant. In a series of articles published in the Psychiatric Services journal, Phillips et al. (2001) reviews an array of evidence about the effectiveness of mental health treatments, finding that, despite all of the research available on interventions, there was "no research specifically on methods for implementing" (p.775) these treatments. It is fortunate that the tide has begun to change and the implementation process is being increasingly recognised for its importance (Barkham et al., 2010; Eccles et al., 2009). Perhaps by looking at the implementation process and real-world research, the ways of improving interventions and services will be discovered. I consider this to be a very exciting time for me in attempting to tackle these complex phenomena, not least because of the skills and expertise I feel I have developed over the course of undertaking this present research project.

Certainly, it is during this research that I feel my drive and determination have been put to the test. I consider this and the experiences that have gone with it to be one of the most enduring challenges I have ever taken on. The research process, for me, is best characterised as a lifestyle, requiring that you engage in a continual process of self-inspection and self-improvement. My confidence to design, coordinate, analyse and critique data has improved, as has the confidence in my verbal and writing skills. I also feel I have a greater awareness and understanding of research methodology, preparing me to become a more competent researcher. I particularly enjoyed the in-depth and meticulous nature of using IPA when exploring and interpreting an individual's experience, which although a particularly time-consuming and labour intensive process, was essential for me in discovering new and valuable insight. Ahead of starting this research project, I found these activities challenging as I felt I could not adequately articulate the human condition, often finding it difficult to verbalise my own emotional experiences. However, since undertaking a foundation course in counselling, and having several publications and conference papers accepted, I feel I have been able to become more adept at exploring these in myself. I also realise how important it is to disseminate research and invite a critical voice to my work, so as to help me gain further insight and improve.

There are certainly barriers to overcome, but with a positive attitude and knowledge about the most relevant and contemporary research, I believe service quality improvement will be achievable. Change takes time and in my learning I have attempted to become more composed and persistent in achieving my aims and objectives in research. I consider myself to be a calm, conscientious and mindful researcher, now able to objectively support and supervise others, mainly due to the transformative experience I have had in undertaking this project.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

10 References

Addicott, R., Maguire. D., Honeyman, M., & Jabbal, J. (2015). *Workforce planning in the NHS*. London: The King's Fund.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179-211.

Ali, S., Littlewood, E., McMillan, D., Delgadillo, J., Miranda, A., Croudace, T., & Gilbody, S. (2014). Heterogeneity in patient-reported outcomes following low-intensity mental health interventions: A multilevel analysis. *PLoS One*, 10(9), e99658.

Allen, J. D., Linnan, L. A., Emmons, K. M. (2012). Fidelity and its relationship to implementation effectiveness, adaptation, and dissemination. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds). *Dissemination and implementation in health: Translating science to practice* (p.281–304). New York: Oxford University Press.

Almlöv, J., Carlbring, P., Källqvist, K., Paxling, B., Cuijpers, P., & Andersson, G. (2011). Therapist effects in guided internet-delivered CBT for anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 39(03), 311-322.

Altson, C., Loewenthal, D., Gaitanidis, A., & Thomas, R. (2014). What are the perceived implications, if any, for non-IAPT therapists working in an IAPT service? *British Journal of Guidance & Counselling*, 43(5), 383-396.

Anderson, N. B. (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271-285.

Anderson, S., & Brownlie, J. (2011). Build it and they will come? Understanding public views of 'emotions talk' and the talking therapies. *British Journal of Guidance & Counselling*, 39(1), 53-66.

Appleby, J., Baird, B., Thompson, J., & Jabbal, J. (2015). *The NHS under the coalition government Part two: NHS performance*. London: The King's Fund.

Arends, I., Baer, N., Miranda, V., Prinz, C., & Singh, S. (2014, November 20). Mental Health and Work. *OECD Publishing*. doi:10.1787/5jxsvvn6pq6g-en.

Atkins, L., Smith, J. A., Kelly, M. P., & Michie, S. (2013). The process of developing evidence-based guidance in medicine and public health: A qualitative study of views from the inside. *Implementation Science*, 8(1), 101.

BACP. (2013). *Ethical Framework for Good Practice in Counselling & Psychotherapy* (4th Ed.). Lutterworth: British Association for Counselling & Psychotherapy.

Baddeley, A. (2014) *Experience of Distress and Use of Psychological Therapy: Perspectives from Users of an IAPT Service*. Professional doctorate thesis. University of East London.

Badham, B., & Young Minds. (2011). *Talking about Talking Therapies: Thinking and planning about how to make good and accessible talking therapies available to children and young people*. March 2011. London: Young Minds.

Balmer, S. (2014). "Hold Fast That Which Is Good". *Healthcare Counselling & Psychotherapy Journal*, 14(3), 8–15.

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence*. Chichester: Wiley.

Barkham, M., Stiles, W. B., Connell, J., & Mellor-Clark, J. (2012). Psychological treatment outcomes in routine NHS services: What do we mean by treatment effectiveness? *Psychology and Psychotherapy: Theory, Research and Practice*, 85(1), 1-16.

Barnes, H. (2011). Does mental illness have a place alongside social and recovery models of mental health in service users' lived experiences? Issues and implications for mental health education. *The Journal of Mental Health Training, Education and Practice*, 6(2), 65-75.

Barnes, M., Sherlock, S., Thomas, L., Kessler, D., Kuyken, W., Owen-Smith, A., ... & Turner, K. (2013). No pain, no gain: Depressed clients' experiences of cognitive behavioural therapy. *British Journal of Clinical Psychology*, 52(4), 347-364.

Barrett, P. (2009). An uncertain prognosis. *Mental Health Practice*, 12(6), 12–15.

Bassey, S., & Melluish, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly*, 25(3), 223-238.

Bassey, S., & Melluish, S. (2013). Cultural competency for mental health practitioners: A selective narrative review. *Counselling Psychology Quarterly*, 26(2), 151-173.

Bastiampillai, T., Jones, G. M., Furber, G., Moreau, M., Healey, D., Watson, J., & Battersby, M. (2014). The IAPT@ Flinders Service: Adapting the Improving Access to Psychological Therapies model to the emergency department setting in Australia. *Australasian Psychiatry*, 22(3), 277-280.

Beattie, A., Shaw, A., Kaur, S., & Kessler, D. (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: A qualitative study. *Health Expectations*, 12(1), 45-59.

Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies*, 45(3), 442-457.

Bennett-Levy, J., Richards, D. A., & Farrand, P. (2010). Low intensity CBT interventions: A revolution in mental healthcare. Low intensity CBT interventions. In J. Bennett-Levy, D. Richards, P. Farrand, H. Christensen, K. Griffiths, D. Kavanagh, … & B. Klein (Eds). *Oxford Guide to Low Intensity CBT Interventions* (p.3-18). Oxford: Oxford University Press.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin.

Biggerstaff, D. L., & Thompson, A. R. (2008). Interpretative phenomenological analysis: A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5, 173-183.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, 20(2).

Black, N. (2001). Evidence based policy: Proceed with care. *BMJ*, 323(7307), 275.

Black, C. (2008). *Dame Carol Black's Review of the Health of Britain's Working Age Population. Working for a Healthier Tomorrow*. London: The Stationery Office.

Blaikie, N. (2007) *Approaches to Social Inquiry* (2nd Ed.). Cambridge: Polity Press.

Bliss-Holtz, J. (2007). Evidence-based practice: A primer for action. *Issues in Comprehensive Pediatric Nursing*, 30(4), 165-182.

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. London: University of California Press.

Bogart, K. (2015). 'Sometimes, I feel that the psychological well-being practitioner role is undervalued'. *The Psychologist*, 28, 236-239.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan., S. D. Miller, B., E. Wampold, & A. Hubble (Eds.)., *The heart and soul of change: Delivering what works in therapy* (2nd Ed.) (p.83-111). Washington, DC, US: American Psychological Association.

Böhnke, J. R., Lutz, W., & Delgadillo, J. (2014). Negative affectivity as a transdiagnostic factor in patients with common mental disorders. *Journal of Affective Disorders*, 166, 270–278.

Bolton, G. E. J. (2014). *Reflective Practice: Writing and Professional Development*. London: SAGE Publications.

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, 25(1), 6-19.

Bower, P., Kontopantelis, E., Sutton, A., Kendrick, T., Richards, D. A., Gilbody, S., ... & Liu, E. T. H. (2013). Influence of initial severity of depression on effectiveness of low intensity interventions: Meta-analysis of individual patient data. *BMJ*, 346.

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: Access, effectiveness and efficiency Narrative literature review. *The British Journal of Psychiatry*, 186(1), 11-17.

Bower, P., Wallace, P., Ward, E., Graffy, J., Miller, J., Delaney, B., & Kinmonth, A. L. (2009). Improving recruitment to health research in primary care. *Family Practice*, cmp037.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., ... & Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201(6), 430-434.

Bradley, S., & Drapeau, M. (2014). Increasing access to mental healthcare through government-funded psychotherapy: The perspectives of clinicians. *Canadian Psychology/Psychologie canadienne*, 55(2), 80.

Brazier, J., Connell, J., Papaioannou, D., Mukuria, C., Mulhern, B., Peasgood, T., ... & Parry, G. (2014). A systematic review, psychometric analysis and qualitative assessment of generic preference-based measures of health in mental health populations and the estimation of mapping functions from widely used specific measures. *Health Technology Assessment*, 18(34).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21(1), 87-108.

Brown, B. S. (1995). Reducing impediments to technology transfer in drug abuse programming. In T. E. Backer, S. L. David, & G. Soucy (Eds.)., *Reviewing the Behavioral Science Knowledge Base on Technology Transfer* (NIDA Monograph, 155. Rockville, NIH Publication No. 95-4035) (p.169.185). Rockville, MD, National Institute on Drug Abuse.

Brown, J. S. L., Boardman, J., Whittinger, N., & Ashworth, M. (2010). Can a self-referral system help improve access to psychological treatments? *British Journal of General Practice*, 60(574), 365–371.

Brown, J. S. L., Ferner, H., Wingrove, J., Aschan, L., Hatch, S. L., & Hotopf, M. (2014). How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough. *Social Psychiatry and Psychiatric Epidemiology*, 49(12), 1893-1902.

Brownson, R. C., Colditz, G. A., & Proctor, E. K. (2012). *Dissemination and implementation in health: Translating science to practice*. New York: Oxford University Press

Bryman, A. (2012). Interviewing in qualitative research. In A. Bryman (4th Ed.), *Social Research Methods* (p.468-500). Oxford: Oxford University Press.

Buckingham, C. D., Ahmed, A., & Adams, A. (2013). Designing multiple user perspectives and functionality for clinical decision support systems. In *Computer Science and Information Systems (FedCSIS), 2013 Federated Conference* on (p.211-218). IEEE.

Buckman, J. E. J. (2014). *Depression: Can we predict who will relapse?* Doctoral dissertation: University College London.

Budd, R., & Hughes, I. (2009). The Dodo Bird Verdict—controversial, inevitable and important: A commentary on 30 years of meta-analyses. *Clinical Psychology & Psychotherapy*, 16(6), 510-522.

Byng, R., & Gask, L. (2009). Improving access to psychological therapies: Implications for mental healthcare in general practice. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners*, 59(566), 640–641.

Byng, R., Newbold, L., Qureshi, A., Weyer-Brown, C., Bannon, J., Pooler, J., … & Anderson, R. (2011). *The South West Improving Access to Psychological Therapies (IAPT) Evaluation Study – Interim Report*. South West Strategic Health Authority: Department of Health.

Cairns, M. (2014). Patients who come back: Clinical characteristics and service outcome for patients re-referred to an IAPT service. *Counselling & Psychotherapy Research*, 14(1), 48–55.

Callan, S., & Fry, B. (2012). *Completing the Revolution: Commissioning Effective Talking Therapies*. London: Centre for Social Justice.

Campbell, P. (2005). *From little acorns. The mental health service user movement.* Sainsbury Centre for Mental Health. Beyond the Water Towers. The Unfinished Revolution in Mental Health Services (Eds.). Retrieved 13th May 2014 from: http://studymore.org.uk/pcacorns.pdf.

Campbell, P. (2013). Service Users and Survivors in J. Cromby, D. Harper, & P. Reavey (Eds.)., *Psychology, Mental Health and Distress* (p.139-157). Basingstoke: Palgrave MacMillan.

Cameron, J., Walker, C., Hart, A., Sadlo, G., & Haslam, I. (2012). Supporting workers with mental health problems to retain employment: Users' experiences of a UK job retention project. *Work*, 42(4), 461-471.

Carey, T. A., Mansell, W. & Tai, S. (2015). *Principles-based Counselling and Psychotherapy: A Method of Levels approach*. (p.23-39). Hove: Routledge.

Cavanagh, K. (2014). Geographic inequity in the availability of cognitive behavioural therapy in England and Wales: A 10-year update. *Behavioural and Cognitive Psychotherapy*, 42(4), 497–501.

Cavanagh, K., Seccombe, N., & Lidbetter, N. (2011). The implementation of computerized cognitive behavioural therapies in a service user-led, third sector self help clinic. *Behavioural and Cognitive Psychotherapy*, 39(04), 427-442.

Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin, & Y. S. Lincoln (4th Ed.). *The SAGE handbook of qualitative research.* (p.359-380). London: SAGE Publications.

Chan, S. W. Y., & Adams, M. (2014). Service use, drop-out rate and clinical outcomes: A comparison between high and low intensity treatments in an IAPT service. *Behavioural and Cognitive Psychotherapy*, 1–13.

Chan, Z. C., Fung, Y. L., & Chien, W. T. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The Qualitative Report*, 18(30), 1-9.

Chinn, D., Abraham, E., Burke, C., & Davies, J. (2014). *IAPT and Learning Disabilities: Research Report*. London: King's College London.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 23(4), 318-327.

Clark, D. M., & Oates, M. (2014). *Improving Access to Psychological Therapies: Measuring Improvement and Recovery Adult Services. Version 2: June 2014*. London: NHS England.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11), 910-920.

Centre for Mental Health. (2010). *The Economic and Social Costs of Mental Health Problems in 2009/10*. London: Centre for Mental Health.

Collins, G. (2012). Brief Dynamic Interpersonal Therapy–is it fitting in primary care? *Psychodynamic Practice*, 18(1), 105-116.

Commission on Social Determinants of Health. (2008). *Closing the Gap in a Generation: Health Equity through action on the Social Determinants of Health. Final Report.* Geneva: World Health Organization.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, 19(5), 2-14.

Cooper, B. (2009). Strange bedfellows: Economics, happiness and mental disorder. *Epidemiologia E Psichiatria Sociale-an International Journal for Epidemiology and Psychiatric Sciences*, 18(3), 208–213.

Cooper, M. (2011). Meeting the demand for evidence-based practice. *Therapy Today*, 22(4), 10-16.

Costa, B., & Briggs, S. (2014). Service-users' experiences of interpreters in psychological therapy: A pilot study. *International Journal of Migration, Health and Social Care*, 10(4), 231-244.

Coulter, A., Locock, L., Ziebland, S., & Calabrese, J. (2014). Collecting data on patient experience is not enough: They must be used to improve care. *BMJ*, 348, g2225.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *BMJ*, 337, a1655.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd Ed.). London: SAGE Publications.

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: A meta-analysis of direct comparisons. *World Psychiatry*, 12(2), 137-148.

Cuijpers, P., van Straten, A., Smit, F., Mihalopoulos, C., & Beekman, A. (2008). Preventing the onset of depressive disorders: A meta-analytic review of psychological interventions. *American Journal of Psychiatry*, 165(10), 1272-1280.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, 4(1), 50.

Dance, M. (2015). *2014 Adult IAPT Workforce Census Report*. London: IAPT Programme NHS England. Available at www.iapt.nhs.uk.

Department for Communities and Local Government. (2011). *The English Indices of Deprivation 2010*. London: Department for Communities and Local Government.

de Lusignan, S., Chan, T., Parry, G., Dent-Brown, K., & Kendrick, T. (2011). Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: A before and after comparison. *Journal of Epidemiology and Community Health*, 66(6), e10.

Delgadillo, J., Gellatly, J., & Stephenson-Bellwood, S. (2013). Decision Making in Stepped Care: How Do Therapists Decide Whether to Prolong Treatment or Not? *Behavioural and Cognitive Psychotherapy*, 43(03), 328-341.

Delgadillo, J., McMillan, D., Leach, C., Lucock, M., Gilbody, S., & Wood, N. (2014a). Benchmarking routine psychological services: A discussion of challenges and methods. *Behavioural and Cognitive Psychotherapy*, 42(1), 16-30.

Delgadillo, J., McMillan, D., Lucock, M., Leach, C., Ali, S., & Gilbody, S. (2014b). Early changes, attrition, and dose–response in low intensity psychological interventions. *British Journal of Clinical Psychology*, 53(1), 114-130.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J., ... & Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA: The Journal of the American Medical Association*, 291(21), 2581-2590.

Dezetter, A., Briffault, X., Lakhdar, C. B., & Kovess-Masfety, V. (2013). Costs and benefits of improving access to psychotherapies for common mental disorders. *Journal of Mental Health Policy and Economics*, 16(4), 161-77.

DH. (2005). *Research Governance Framework for Health and Social Care* (2nd Ed.). London: Department of Health.

DH. (2007). *Patient Pathways*. London: Department of Health.

DH. (2008). *IAPT Implementation Plan: National Guidelines for Regional Delivery*. London: Department of Health.

DH. (2011a). *No Health Without Mental Health: A Cross-Government Mental Health Strategy for People of All Ages*. London: Department of Health.

DH. (2011b). *NHS Operating Framework 2012–13*. London: Department of Health.

Di Bona, L., Saxon, D., Barkham, M., Dent-Brown, K., & Parry, G. (2014). Predictors of patient non-attendance at Improving Access to Psychological Therapy services demonstration sites. *Journal of Affective Disorders*, 169C, 157–164.

Dickens, G., & Picchioni, M. (2012). A systematic review of the terms used to refer to people who use mental health services: User perspectives. *International Journal of Social Psychiatry*, 58(2), 115-122.

Docherty, M., & Thornicroft, G. (2015). Specialist mental health services in England in 2014: Overview of funding, access and levels of care. *International Journal of Mental Health Systems*, 9(1), 1-8.

Dodd, K., Joyce, T., Nixon, J., Jennison, J., & Heneage, C. (2011). Improving access to psychological therapies (IAPT): Are they applicable to people with intellectual disabilities? *Advances in Mental Health and Intellectual Disabilities*, 5(2), 29-34.

Dormon, F. (2015, June 23). IAPT and targets: What has been achieved, and where next? *The Health Foundation*. Retrieved 24th June 2015 from: http://www.health.org.uk/blog/iapt-and-targets-what-has-been-achieved-and-where-next.

Dowrick C. (2004). *Beyond depression: A new approach to understanding and management.* Oxford: Oxford University Press.

Duncan, B., & Miller, S, (2006). Treatment manuals do not improve outcomes. In J. Norcross, R. Levant, & L. Beutler (Eds.), *Evidence-based practices in mental health* (p.140-148). London: American Psychological Association.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy* (2nd Ed.). Washington, DC: APA Press.

Eady, A. M., Wilczynski, N. L., Haynes, R. B., & Hedges Team. (2008). PsycINFO search strategies identified methodologically sound therapy studies and review articles for use by clinicians and researchers. *Journal of Clinical Epidemiology*, 61(1), 34-40.

Easby, R. (2010). *A Qualitative Study of Patients' Perceptions of Guided Self-Help for Anxiety*. Professional doctorate thesis: University of East Anglia.

Eatough, V., & Smith, J. A. (2008) Interpretative phenomenological analysis. In C. Willing & W. Stainton-Rogers (Eds)., *The SAGE handbook of qualitative research in psychology*. (pp 179-194). London: SAGE Publications.

Eccles, M. P., Armstrong, D., Baker, R., Cleary, K., Davies, H., Davies, S., ... & Sibbald, B. (2009). An implementation research agenda. *Implementation Science*, 4(1), 18.

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science*, 1(1), 1-3.

Eliacin, J., Salyers, M. P., Kukla, M., & Matthias, M. S. (2015). Factors influencing patients' preferences and perceived involvement in shared decision-making in mental healthcare. *Journal of Mental Health*, 24(1), 24-28.

Evans, B. A., Snooks, H., Howson, H., & Davies, M. (2013). How hard can it be to include research evidence and evaluation in local health policy implementation? Results from a mixed methods study. *Implementation Science*, 8(7), 1-9.

Evans-Lacko, S., Henderson, C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012. *The British Journal of Psychiatry*, 202(s55), s51-s57.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J., ... & Whiteford, H. A. (2013). Burden of depressive disorders by country, sex,

age, and year: Findings from the global burden of disease study 2010. *PLoS Medicine*, e1001547.

Finch, T. L., Mair, F. S., O'Donnell, C., Murray, E., & May, C. R. (2012). From theory to 'measurement' in complex interventions: Methodological lessons from the development of an e-health normalisation instrument. *BMC Medical Research Methodology*, 12(1), 69.

Finch, T. L., Rapley, T., Girling, M., Mair, F. S., Murray, E., Treweek, S., ... & May, C. R. (2013). Improving the normalization of complex interventions: Measure development based on normalization process theory (NoMAD): Study protocol. *Implementation Science*, 8, 43.

Finlay, L. (2008). *Reflecting on 'Reflective practice*'. The Open University. Retrieved 14th April 2014 from: http://www.open.ac.uk/opencetl/files/opencetl/file/ecms/web-content/Finlay-(2008)-Reflecting-on-reflective-practice-PBPL-paper-52.pdf.

Finlay, L. (2008). A Dance Between the Reduction and Reflexivity: Explicating the" Phenomenological Psychological Attitude". *Journal of Phenomenological Psychology*, 39(1), 1-32.

Finlay, L. (2009). Debating phenomenological methods. *Phenomenology & Practice*, 3(1), 6-25.

Finlay, L. (2012). Unfolding the phenomenological research process: Iterative stages of "seeing afresh". *Journal of Humanistic Psychology*, 53(2), 172-201.

Firth, N., Barkham, M., & Kellett, S. (2015). The clinical effectiveness of stepped care systems for depression in working age adults: A systematic review. *Journal of Affective Disorders*, 170, 119-130.

Firth, N., Barkham, M., Kellett, S., & Saxon, D. (2015). Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis. *Behaviour Research and Therapy*, 69, 54-62.

Firth-Lewis, B., Carr, J., Russell-Smith, S., Haghighi, S., Denton, L., & Lennox, C. (2013). Dual diagnosis: Wakefield district partners in provision of effective treatment for adults with substance misuse and mental health conditions. *Mental Health Nursing (Online)*, 33(3), 12.

Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *JAMA*, 303(1), 47-53.

Franx, G., Oud, M., de Lange, J., Wensing, M., & Grol, R. (2012). Implementing a stepped-care approach in primary care: Results of a qualitative study. *Implementation Science*, 7(1), 8.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13(1), 117.

Gask, L., Bower, P., Lovell, K., Escott, D., Archer, J., Gilbody, S., ... & Richards, D. (2010). What work has to be done to implement collaborative care for depression? Process evaluation of a trial utilizing the Normalization Process Model. *Implementation Science*, 5(15), 1-11.

Gaynor, K., & Brown, J. S. (2013). Self-referrers to community workshops: Who are they and why do some participants not consult with their GP about their mental health difficulties? *Journal of Mental Health*, 22(3), 227-236.

Gellatly, J. (2011). *Decision making in stepped care for common mental health problems*. PhD Thesis. University of Manchester, School of Nursing, Midwifery and Social Work.

Gilburt, H., Peck, E., Ashton, R., Edwards, N., & Naylor, C. (2014). *Service transformation: Lessons from mental health*. London: The King's Fund.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine Transaction.

Glover, G., Webb, M., & Evison, F. (2010). *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year*. Stockton-On-Tees: North East Public Health Observatory.

Goddard, E., Wingrove, J., & Moran, P. (2015). The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety. *Behaviour Research and Therapy*, 73, 1-7.

Goeting, N. (2009). Outcome measurement and IAPT: The Dorset experience. *Healthcare Counselling & Psychotherapy Journal*, 9(3), 43–47.

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, 21(2), 135-146.

Grant, N., Hotopf, M., Breen, G., Cleare, A., Grey, N., Hepgul, N., ... & Tylee, A. (2014). Predicting outcome following psychological therapy in IAPT (PROMPT): A naturalistic project protocol. *BMC Psychiatry*, 14(1), 170.

Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy*, 63, 43-54.

Green, S. A., Honeybourne, E., Chalkley, S. R., Poots, A. J., Woodcock, T., Price, G., ... & Green, J. (2015). A retrospective observational analysis to identify patient and treatment-related predictors of outcomes in a community mental health programme. *BMJ Open*, 5(5), e006103.

Green, S. A., Poots, A. J., Marcano-Belisario, J., Samarasundera, E., Green, J., Honeybourne, E., & Barnes, R. (2013). Mapping mental health service access: Achieving equity through quality improvement. *Journal of public health*, 35(2), 286-292.

Greene, J. C. (2006). Toward a methodology of mixed methods social inquiry. *Research in the Schools*, 13(1), 93–98.

Griffiths, L. (2003). Making connections: Studies of the social organisation of healthcare. *Sociology of Health & Illness*, 25(3), 155-171.

Griffiths, S., Foster, J., Steen, S., Pietroni, P. (2013). Mental health's market Experiment: Commissioning psychological therapies through Any Qualified Provider. Report No. 1. *Centre for Psychological Therapies in Primary Care*. University of Chester.

Griffiths, C. A., & Griffiths, L. J. (2015). Recovery and reliable change rates for patients scoring severe on depression, anxiety or impaired functioning in a psychological therapies service: IAPT. *Mental Health Review Journal*, 20(1), 28-35.

Griffiths, S. & Steen, S. (2013a). Improving Access to Psychological Therapies (IAPT) Programme - Setting Key Performance Indicators in a more robust context: A new perspective. *The Journal of Psychological Therapies in Primary Care*, 2(2), 133-141.

Griffiths, S., & Steen, S. (2013b). Improving Access to Psychological Therapies (IAPT) Programme: Scrutinising IAPT cost estimates to support effective commissioning. *The Journal of Psychological Therapies in Primary Care*, 2(2), 142-156.

Grimshaw, J. M., Eccles, M. P., Lavis, J. N., Hill, S. J., & Squires, J. E. (2012). Knowledge translation of research findings. *Implementation Science*, 7(1), 50.

Grove, B. (2006). Common mental health problems in the workplace: How can occupational physicians help? *Occupational Medicine*, 56(5), 291-293.

Gunn, J. M., Palmer, V. J., Dowrick, C. F., Herrman, H. E., Griffiths, F. E., Kokanovic, R., ... & May, C. R. (2010). Embedding effective depression care: Using theory for primary care organisational and systems change. *Implementation Science*, 5(62), 1-15.

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice*, 18(1), 25-50.

Gyani, A., Pumphrey, N., Parker, H., Shafran, R., & Rose, S. (2012). Investigating the use of NICE guidelines and IAPT services in the treatment of depression. *Mental Health in Family Medicine*, 9(3), 149-160.

Gyani, A., Shafran, R., Layard, R., & Clark, D. (2011). *Enhancing Recovery Rates in IAPT Services: Lessons from analysis of the Year One data*. London: LSE Research Online.

Haarhoff, B., Thwaites, R., & Bennett- Levy, J. (2015). Engagement with Self-Practice/Self- Reflection as a Professional Development Activity: The Role of Therapist Beliefs. *Australian Psychologist,* 50(5), 322-328.

Hamilton, S., Hicks, A., Sayers, R., Faulkner, A., Larsen, J., Patterson, S., & Pinfold, V. (2011). *A user-focused evaluation of IAPT services in London.* London: Rethink.

Hammond, G. C., Croudace, T. J., Radhakrishnan, M., Lafortune, L., Watson, A., McMillan-Shields, F., & Jones, P. B. (2012). Comparative effectiveness of cognitive therapies delivered face-to-face or over the telephone: An observational study using propensity methods. *PloS One,* 7(9).

Harding, E., Pettinari, C. J., Brown, D., Hayward, M., & Taylor, C. (2011). Service user involvement in clinical guideline development and implementation: Learning from mental health service users in the UK. *International Review of Psychiatry*, 23(4), 352-357.

Harvey, S. B., Henderson, M., Lelliott, P., & Hotopf, M. (2009). Mental health and employment: Much work still to be done. *The British Journal of Psychiatry*, 194(3), 201-203.

Hashtroudi, A., & Paterson, H. (2009). Occupational health advice in NICE guidelines. *Occupational Medicine,* 59(5), 353-356.

Hatzidimitriadou, E., Mantovani, N., & Keating, F. (2012). *Evaluation of co-production processes in a community-based mental health project in Wandsworth*. London: Kingston University/St George's University of London.

Hayes, A. M., Laurenceau, J. P., Feldman, G., Strauss, J. L., & Cardaciotto, L. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review*, 27(6), 715-723.

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, 12(4), 335-344.

Heaton, J. (2004). What is Secondary Analysis? In *Reworking qualitative data* (p.1-19). London: SAGE Publications.

Hiles, D. R. (2008). Heuristic Inquiry. In L. M. Given. (2008). *The SAGE Encyclopedia of Qualitative Research Methods* (p.390-393). London: SAGE Publications.

Hofmann, S. G. (2013). Bridging the theory-practice gap by getting even bolder with the Boulder model. *Behavior Therapy*, 44(4), 603-608.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, 36(5), 427-440.

Hogarth, T., Hasluck, C., Gambin, L., Behle, H., Li, Y., & Lyonette, C. (2013). *Evaluation of Employment Advisers in the Improving Access to Psychological Therapies programme*. DWP Research Report 826. London: Department for Work and Pensions.

Holmes, J. (2002). All you need is cognitive behaviour therapy? *BMJ*, 324(7332), 288.

HSCIC. (2014a). *Psychological Therapies, Annual Report on the use of IAPT services: England – 2013-14 EXPERIMENTAL STATISTICS*. Community and Mental Health Team: Health and Social Care Information Centre.

HSCIC. (2014b). *Psychological Therapies, Annual Report on the use of IAPT services: England – 2012-13 EXPERIMENTAL STATISTICS*. Community and Mental Health Team, Health and Social Care Information Centre.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, 15(9), 1277-1288.

IAPT. (2008a). *The IAPT Pathfinders: Achievement and Challenges*. London: Department of Health.

IAPT. (2008b). *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit.* London: Department of Health.

IAPT. (2008c). *Commissioning IAPT for the Whole Community: Improving Access to Psychological Therapies*. London: Department of Health.

IAPT. (2008d). *Improving Access to Psychological Therapies (IAPT) Supervision Guidance*. London: Department of Health.

IAPT. (2009). *Improving Access to Psychological Therapies (IAPT) Learning Disabilities: Positive Practice Guide*. London: Department of Health.

IAPT. (2011a). *National Curriculum for the Education of Psychological Wellbeing Practitioners*. Improving Access to Psychological Therapies: Department of Health.

IAPT. (2011b). *The IAPT Data Handbook (v 2.0).* Improving Access to Psychological Therapies: Department of Health.

IAPT. (2012). *IAPT three-year report. The first million patients*. Improving Access to Psychological Therapies: Department of Health.

IAPT. (2015). *Patient Experience Questionnaire. Assessment and Treatment Resource*. Improving Access to Psychological Therapies. Retrieved 29th April 2015 from: http://www.iapt.nhs.uk/silo/files/patient-experience-questionnaire.doc.

Institute of Medicine. (2001). *Crossing The Quality Chasm: A New Health System for The 21st Century*. Institute of Medicine Committee on Quality of Healthcare in America. Washington, DC: National Academy Press.

Israel, M., & Hay, I. (2006). *Research ethics for social scientists*. (p.23-40). London: SAGE Publications.

Jackson, C. (2013). Patients by numbers. *Therapy Today*, 24(3).

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), 12.

Jamieson, J., & White, J (2008). Ethnic minority mental health: Opening the doors of a primary care mental health service. *Clinical Psychology Forum*, 190, 33-38.

Jones, E. A., Bale, H. L., & Morera, T. (2013). A qualitative study of clinician's experiences and attitudes towards telephone triage mental health assessments. *The Cognitive Behaviour Therapist*, 6, e17.

Jupp, B. (2015). *Reconsidering accountability in an age of integrated care. Nuffield Trust Viewpoint*. London: Nuffield Trust.

Kaplan, R. B., & Grabe, W. (2002). A modern history of written discourse analysis. *Journal of Second Language Writing*, 11(3), 191-223.

Kendall, T., Pilling, S., Glover, N., & Taylor, C. (2011). Guidelines in mental health–National and international perspectives. *International Review of Psychiatry*, 23(4), 314-317.

Kendall, T., Pilling, S., Whittington, C., Pettinari, C., & Burbeck, R. (2005). Clinical Guidelines in Mental Health II: A guide to making NICE Guidelines. *Psychiatric Bulletin*, 29(1), 3-8.

Kendrick, T., Dowrick, C., McBride, A., Howe, A., Clarke, P., Maisey, S., ... & Smith, P. W. (2009). Management of depression in UK general practice in relation to scores on depression severity questionnaires: Analysis of medical record data. *BMJ*, 338.

Kendrick, T., & Peveler, R. (2010). Guidelines for the management of depression: NICE work? *The British Journal of Psychiatry: The Journal of Mental Science*, 197(5), 345–7.

Kenwright, M. (2008). *Patients preferences and outcomes with self-help for depression: On-line CCBT Vs standalone CCBT Vs workbook: A naturalistic study.* Paper presented at the British Association of Behavioural and Cognitive Psychotherapy Conference, Warwick, July.

Kenwright, M. (2009). *Lessons learnt in implementing low intensity treatment within IAPT stepped- care services*. Paper presented at the British Association of Behavioural and Cognitive Psychotherapy Conference, Exeter, July.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

Khan, N., Bower, P. & Rogers, A. (2007), Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience. *British Journal of Psychiatry*, 191, 206–211.

King, M., Nazareth, I., Levy, G., Walker, C., Morris, R., Weich, S., ... & Torres-Gonzalez, F. (2008). Prevalence of common mental disorders in general practice attendees across Europe. *The British Journal of Psychiatry*, 192(5), 362-367.

Kirk, J., Sehmi, A., Hazeldine, C., Palmer, G., & Ruddle, G. (2013). LIFT psychology primary care group for people with intellectual disabilities: Can IAPT adapt? *Advances in Mental Health and Intellectual Disabilities*, 8(1), 51-62.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PLoS Medicine*, 5(2), e45.

Knaup, C., Koesters, M., Schoefer, D., Becker, T., & Puschner, B. (2009). Effect of feedback of treatment outcome in specialist mental healthcare: Meta-analysis. *The British Journal of Psychiatry*, 195(1), 15-22.

Knowles, S. E., Chew-Graham, C., Coupe, N., Adeyemi, I., Keyworth, C., Thampy, H., & Coventry, P. A. (2013). Better together? A naturalistic qualitative study of inter-professional working in collaborative care for comorbid depression and physical health problems. *Implementation Science*, 8(1), 110.

Kobori, O., Nakazato, M., Yoshinaga, N., Shiraishi, T., Takaoka, K., Nakagawa, A., ... & Shimizu, E. (2014). Transporting Cognitive Behavioral Therapy (CBT) and the Improving Access to Psychological Therapies (IAPT) project to Japan: Preliminary observations and service evaluation in Chiba. *The Journal of Mental Health Training, Education and Practice*, 9(3), 155-166.

Kroenke, K., Spitzer, R.L. & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General and Internal Medicine*, 16, 606–613.

Kuhn, P. (2011). Improving access to psychological therapies: Systemic therapy in the Newham pilot site. *Journal of Family Therapy*, 33(4), 400–414.

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research (p.99-116.). In D. Harper, & A. R. Thompson (Eds.)., *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*. Chichester: John Wiley & Sons.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120.

Layard, R. (2006). Health policy: The case for psychological treatment centres. *BMJ*, 332(7548), 1030-32.

Layard, R. Banerjee, S., Bell, S., Clark, D. M., Field, S., & Knapp, M. (2012). *Mental illness loses out in the NHS. A Report by The Centre for Economic Performance's Mental Health Policy Group*. London: The London School of Economics and Political Science.

Layard, R., Bell, S., Clark, D.M., Knapp, M., Meacher, M., Priebe, S. & Wright, B. (2006). *The Depression Report: A New Deal for Depression and Anxiety Disorders. Centre for Economic Performance Report*. London: London School of Economics. Retrieved from: http//cep.lse.ac.uk.

Layard, R., & Clark, D. M. (2014). *Thrive: The power of evidence-based psychological therapies*. Penguin UK.

Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, 202(1), 90-98.

Lees J. (2008) Cognitive-behavioural therapy and evidence based practice: Past, present and future. *European Journal of Psychotherapy and Counselling*, 10(3), 187–196.

Lewis, A. M. (2012). Organisations adjusting to change: A discussion of the impact of an Improving Access to Psychological Therapies (IAPT) service on the organisational dynamics of an existing psychological therapies department. *Counselling Psychology Review*, 27(1), 22–29.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: SAGE Publications.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin, & Y. S. Lincoln. *The SAGE handbook of qualitative research* (4th Ed.). London: SAGE Publications.

Linde, K., Sigterman, K., Kriston, L., Rücker, G., Jamil, S., Meissner, K., & Schneider, A. (2015). Effectiveness of psychological treatments for depressive disorders in primary care: Systematic review and meta-analysis. *The Annals of Family Medicine*, 13(1), 56-68.

Loewenthal, D. (2015). NICE Work if You Can Get It: Evidence and Research in Psychotherapy as Cultural, Politically Influenced Practices. *The Journal of Psychological Therapies in Primary Care*, 4(1), 26-46.

Lovell, K. (2010). Supporting low intensity interventions using the telephone. In J. Bennett-Levy, D. Richards, P. Farrand, H. Christensen, K. Griffiths, D. Kavanagh, … & B. Klein (Eds)., *Oxford Guide to Low Intensity CBT Interventions* (p.275-280). Oxford: Oxford University Press.

Lovell, K., Lamb, J., Gask, L., Bower, P., Waheed, W., Chew-Graham, C., ... & Dowrick, C. (2014). Development and evaluation of culturally sensitive psychosocial interventions for under-served people in primary care. *BMC Psychiatry*, 14(1), 217.

Lucas, S. R. (2014). Beyond the existence proof: Ontological conditions, epistemological implications, and in-depth interview research. *Quality & Quantity*, 48(1), 387-408.

Lucock, M., Barber, R., Jones, A., & Lovell, J. (2007). Service users' views of self-help strategies and research in the UK. *Journal of Mental Health*, 16, 795-805.

Lucock, M., Halstead, J., Leach, C., Barkham, M., Tucker, S., Randal, C., ... & Saxon, D. (2015). A mixed-method investigation of patient monitoring and enhanced feedback in routine practice: Barriers and facilitators. *Psychotherapy Research*, 25(6), 633-646.

Marziller, J. & Hall, J. (2009). The challenge of the Layard initiative. *The Psychologist*, 22(5), 396-399.

Midlands Psychology Group (2007). Questioning the science and politics of happiness. *The Psychologist*, 20, 422-425.

Macdonald, W., Mead, N., Bower, P., Richards, D., & Lovell, K. (2007). A Qualitative Study of Patients' Perceptions of a 'Minimal' Psychological Therapy. *International Journal of Social Psychiatry*, 53, 23-35.

MacDonald, J., & Mellor-Clark, J. (2014). Correcting Psychotherapists' Blindsidedness: Formal Feedback as a Means of Overcoming the Natural Limitations of Therapists. *Clinical Psychology & Psychotherapy*, 22(3), 249-257.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education*, 14(4), 595-621.

Mansell, W. (2007). Reading about self-help books on cognitive-behavioural therapy for anxiety disorders. *The Psychiatrist*, 31(6), 238-240.

Marks, I. M., & Cavanagh, K. (2009). Computer-aided psychological treatments: Evolving issues. *Annual Review of Clinical Psychology*, 5, 121–41.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010, The Marmot Review*. London: University College London.

Mathers, N., & Mitchell, C. (2010). Are the gates to be thrown open? *British Journal of General Practice*, 60(574), 317-318.

May, C. (2013). Towards a general theory of implementation. *Implementation* Science, 8(1), 18.

May, C., & Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology*, 43(3), 535-554.

May, C. R., Mair, F., Finch, T., MacFarlane, A., Dowrick, C., Treweek, S., ... & Montori, V. M. (2009). Development of a theory of implementation and integration: Normalization Process Theory. *Implementation Science*, 4(29), 29.

May, C., Murray, E., Finch, T., Mair, F., Treweek, S., Ballini, L., Macfarlane, A. & Rapley, T. (2010). *Normalization Process Theory On-line Users' Manual and Toolkit*. Retrieved 14th June 2013 from: http://www.normalizationprocess.org.

McCambridge, J., De Bruin, M., & Witton, J. (2012). The effects of demand characteristics on research participant behaviours in non-laboratory settings: A systematic review. *PLoS One*, 7(6), e39116.

McConnell-Henry T, Chapman Y, Francis K (2011) Member checking and Heideggerian phenomenology: A redundant component. *Nurse Researcher*, 18(2) 28-37.

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M. & Lawton-Smith, S. (2008). *Paying the price: The cost of mental healthcare in England to 2026*. London: The King's Fund.

McEvoy, R., Ballini, L., Maltoni, S., O'Donnell, C. A., Mair, F. S., & MacFarlane, A. (2014). A qualitative systematic review of studies using the normalization process theory to research implementation processes. *Implementation Science*, 9(1), 2.

McEvoy, P., Schauman, O., Mansell, W., & Morris, L. (2012). The experience of recovery from the perspective of people with common mental health problems: Findings from a telephone survey. *International Journal of Nursing Studies*, 49(11), 1375-1382.

McGorry, P. (2013). Prevention, innovation and implementation science in mental health: The next wave of reform. *The British Journal of Psychiatry*, 202(s54), s3-s4.

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist*, 65(2), 73.

McHugh, R. K., & Barlow, D. H. (Eds.). (2012). *Dissemination and implementation of evidence-based psychological interventions*. New York: Oxford University Press.

McHugh, P., Gordon, M., & Byrne, M. (2014). Evaluating brief cognitive behavioural therapy within primary care. *Mental Health Review Journal*, 19(3), 196-206.

McHugh, R. K., Murray, H. W., & Barlow, D. H. (2009). Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: The promise of transdiagnostic interventions. *Behaviour Research and Therapy*, 47(11), 946-953.

McHugh, R. K., Whitton, S. W., Peckham, A. D., Welge, J. A., & Otto, M. W. (2013). Patient preference for psychological vs. pharmacological treatment of psychiatric disorders: A meta-analytic review. *The Journal of Clinical Psychiatry*, 74(6), 595.

McKeganey, N. (2001). To pay or not to pay: Respondents' motivation for participating in research. *Addiction*, 96, 1237–1238.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: SAGE Publications.

McLeod, J. (2013). *An Introduction to Research in Counselling and Psychotherapy*. London: SAGE Publications.

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey.* University of Leicester: National Centre for Social Research and the Department of Health Sciences.

McPherson, S., Evans, C., & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT? *Journal of Mental Health*, 18(5), 405-414.

Mellor-Clark, J., Cross, S., Macdonald, J., & Skjulsvik, T. (2014). Leading horses to water: Lessons from a decade of helping psychological therapy services use routine outcome measurement to improve practice. *Administration and Policy in Mental Health and Mental Health Services Research*, 43(3), 279-285.

Mental Capacity Act. (2005). *Mental Capacity Act 2005*. London: HSMO. Retrieved 17th October 2013 from: http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf.

Mental Health Today. (2015). *Call for government to improve access to psychological therapies as waiting times still vary widely*. Mental Health Today, 24th September 2015. Retrieved 29th September 2015 from: https://www.mentalhealthtoday.co.uk/call-for-government-to-improve-access-to-psychological-therapies-as-waiting-times-still-vary-widely.aspx.

Merriam S. (1988). *Case study research in education: A qualitative approach*. San Francisco, CA: Jossey-Bass.

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2014). The outcome of psychotherapy: Yesterday, today and tomorrow. *Psychotherapy*, 50(1), 88-97.

Mind. (2010). *We Need to Talk: Getting the Right Therapy at the Right Time*. London: Mind Charity.

Mind. (2011). *Still in the Red: Update on Debt and Mental Health*. London: Mind Charity.

Mind. (2013). *Attitudes to Mental Illness 2012 Research Report*. London: Mind Charity.

Mind. (2014). *An Urgent Need: We Need to Talk's Manifesto for Better Talking Therapies for all*. London: Mind Charity.

Mofrad, L., & Webster, L. A. (2012). The treatment of depression and simple phobia through an interpreter in the North East of England: A case study. *The Cognitive Behaviour Therapist*, 5(04), 102-111.

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice*, 15(1), 9-24.

Moloney, P. (2013). *The Therapy Industry: The Irresistible Rise of the Talking Cure, and Why It Doesn't Work*. London: Pluto Press.

Moran-Ellis, J., Alexander, V. D., Cronin, A., Dickinson, M., Fielding, J., Sleney, J., &. Thomas, H. (2006). Triangulation and integration: Processes, claims and implications. *Qualitative Research*, 6(1), 45–59.

Moreea, O. (2015). Where have all the Psychological Wellbeing Practitioners gone? Debate. *Northern IAPT Practice Research Network: Leeds Community Healthcare NHS Trust*. Retrieved 17th July 2015 from: http://www.iaptprn.com/uploads/3/9/8/5/39859781/debate_pwp_may2015.pdf.

Morison, L., Trigeorgis, C., & John, M. (2014). Are mental health services inherently feminised? *The Psychologist*, 27(6), 414-416.

Mukuria, C., Brazier, J., Barkham, M., Connell, J., Hardy, G., Hutten, R., … Parry, G. (2013). Cost-effectiveness of an Improving Access to Psychological Therapies service. *The British Journal of Psychiatry*, 202(3), 220–227.

Munder, T., Brütsch, O., Leonhart, R., Gerger, H., & Barth, J. (2013). Researcher allegiance in psychotherapy outcome research: An overview of reviews. *Clinical Psychology Review*, 33(4), 501-511.

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. M. (2002). The Work and Social Adjustment Scale: A simple measure of impairment in functioning. *The British Journal of Psychiatry*, 180(5), 461-464.

Murray, E., Treweek, S., Pope, C., MacFarlane, A., Ballini, L., Dowrick, C., ... & May, C. (2010). Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. *BMC Medicine*, 8(1), 63.

Nature Editorial. (2012, September 27). Therapy Deficit. *Nature*, 489(7417), 473-74.

Newnham, E. A., & Page, A. C. (2010). Bridging the gap between best evidence and best practice in mental health. *Clinical Psychology Review*, 30(1), 127-142.

NHS Constitution. (2014a). *Choice in Mental Healthcare: Guidance on implementing patients' legal rights to choose the provider and team for their mental healthcare*. NHS England Policy Document: NHS England/Policy Directorate/Business Planning Team.

NHS Constitution. (2014b). *Putting Patients First: Business Plan 2014-15 to 2016-17*. NHS England Policy Document: NHS England/Policy Directorate/Business Planning Team.

NHS England (2013). *The NHS belongs to the people: A call to action.* Retrieved 15th January 2014 from: http://england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf.

NICE (2004a). *Anxiety: Management of Anxiety (Panic Disorder, With and Without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care*. Clinical Guideline 22. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2004b). *Depression: Management of Depression in Primary and Secondary Care*. Clinical Guideline 23. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2005a). *Obsessive–Compulsive Disorder: Core Interventions in the Treatment of Obsessive–Compulsive Disorder and Body Dysmorphic Disorder*. Clinical Guideline 31. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2005b). *Post-Traumatic Stress Disorder (PTSD): The Management of PTSD in Adults and Children in Primary and Secondary Care*. Clinical Guideline 26. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2006). *Computerised Cognitive Behaviour Therapy for Depression and Anxiety*. Technology Appraisal 97. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2009a). *Depression: Treatment and Management of Depression in Adults*. Clinical Guideline 90. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2009b). *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management.* Clinical Guideline 91. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE. (2009c). *Managing long-term sickness absence and incapacity for work.* Public Health Guideline 19. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE (2011a). *Common Mental Health Disorders: Identification and Pathways to Care.* Clinical Guideline 123. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE. (2011b). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults*. Clinical Guideline 113. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

NICE. (2013). *Social anxiety disorder: Recognition, assessment and treatment.* Clinical Guideline 159. London: National Institute for Health and Clinical Excellence. Retrieved from: www.nice.org.uk.

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, 10(1), 53.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. London: American Psychological Association.

Office for National Statistics. (2014). *UK Census 2011*. Retrieved 13th May 2014 from: http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html.

Ormston, R., Spencer, L., Barnard, M., & Snape, D. (2013). The foundations of qualitative research. In J. Ritchie, & J. Lewis (2nd Ed.)., *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (p.1-26). London: SAGE Publications.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533-44.

Papworth, M., Marrinan, T., Martin, B., Keegan, D., & Chaddock, A. (2013). *Low Intensity Cognitive-Behaviour Therapy: A Practitioner's Guide*. London: SAGE Publications.

Parker, I. (2014). Psychotherapy under Capitalism: The Production, Circulation and Management of Value and Subjectivity. *Psychotherapy and Politics International*, 12(3), 166-175.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., ... & van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, 370(9591), 991-1005.

Pearce, P., Hill, R., Coles, A., Pybis, H., Hunt, J., Robson, J., Lacock, M., Hobman, L., & Trish, P. (2012). Evaluating Counselling for Depression. *Therapy Today*, 23(10), 52–53.

Perring, C. (2010). Mental Illness. *The Stanford Encyclopedia of Philosophy* (Spring 2010 Edition), Zalta, E. N. (Eds.). Retrieved 14th March 2014 from: http://plato.stanford.edu/archives/spr2010/entries/mental-illness/.

Perton, D. (2013). *IAPT Payment by Results Pilot Feasibility Study Final Report*. Version 1.0. London: Improving Access to Psychological Therapies. Retrieved from: www.iapt.nhs.uk.

Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., ... & Herr, E. C. M. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52(6), 771–779.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7-14.

Pietroni, P., Martin, M., Wilkinson, M., Griffiths, T., Goodwille, G., & White, J. (2012). Where We Were –Where We Are –Where Are We Going? WHERE WE ARE. *The Journal of Psychological Therapies in Primary Care*, 1(1-2), 19-31.

Pilgrim, D. (2009). Recovery from mental health problems: Scratching the surface without ethnography. *Journal of Social Work Practice*, 23(4), 475-487.

Pilgrim, D., & Carey, T. (2012). Improving access to psychological therapies: An account of recent policy aspirations in the UK and Australia. *Advances in Mental Health*, 10(2), 117-126.

Pimm, J. (2015). *Two Perspectives: Case Studies on Successfully Meeting Recovery and Access Targets*. Paper presented at the IAPT National Networking Forum Conference, Birmingham, January 2015.

Price, C. (2010). Right steps in providing IAPT services in Wakefield. *Healthcare Counselling & Psychotherapy Journal*, 10(4), 36–41.

Price, J. (2011). Stepping into the shoes of service users. *Mental Health Practice*, 15(1), 26-29.

Price, C. (2013). *IAPT programme struggling to achieve targets*. Pulse Today, 24th October 2013. Retrieved 20th November 2014 from: http://www.pulsetoday.co.uk/clinical/mental-health/iapt-programme-struggling-to-achieve-targets/20004817.fullarticle.

Pringle, J. Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, 18(3), 20.

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(1), 24-34.

Public Health England. (2015). *Community Mental Health Profiles*. Retrieved 14th January 2015 from: http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp.

Radhakrishnan, M., Hammond, G., Jones, P. B., Watson, A., McMillan-Shields, F., & Lafortune, L. (2013). Cost of Improving Access to Psychological Therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. *Behaviour Research and Therapy*, 51(1), 37-45.

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review*, 30(5), 496-516.

Rao, A. S., Hendry, G., & Watson, R. (2010). The implementation of routine outcome measures in a Tier 3 Psychological Therapies Service: The process of enhancing data quality and reflections of implementation challenges. *Counselling and Psychotherapy Research*, 10(1), 32-38.

RCP. (2010). *No health with public mental health: The case for action. Royal College of Psychiatrists. Position statement PS4/2010*. London: Royal College of Psychiatrists.

RCP. (2013). *Report of the Second Round of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT) 2013*. Royal College of Psychiatrists. London: Healthcare Quality Improvement Partnership.

Rennie, D. L. (2012). Qualitative research as methodical hermeneutics. *Psychological Methods*, 17(3), 385.

Richards, D. A., & Borglin, G. (2011). Implementation of Psychological Therapies for Anxiety and Depression in Routine Practice: Two-Year Prospective Cohort Study. *Journal of Affective Disorders*, 133(1-2), 51–60.

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., ... & Vasilakis, C. (2012). Delivering stepped care: An analysis of implementation in routine practice. *Implementation Science*, 7(3), doi: 10.1186/1748-5908-7-3.

Richards, D. A., Lankshear, A. J., Fletcher, J., Rogers, A., Barkham, M., Bower, P., ... & Lovell, K. (2006). Developing a UK protocol for collaborative care: A qualitative study. *General Hospital Psychiatry*, 28(4), 296-305.

Richards, D. A. & Suckling, R. (2009). Improving Access to Psychological Therapies: Phase IV, prospective cohort study. *British Journal of Clinical Psychology*, 48, 377–396.

Richardson, R., Richards, D. A., & Barkham, M. (2010). Self-help books for people with depression: The role of the therapeutic relationship. *Behavioural and Cognitive Psychotherapy*, 38(01), 67-81.

Rizq, R. (2011). IAPT, anxiety and envy: A psychoanalytic view of NHS primary care mental health services today. *British Journal of Psychotherapy*, 27(1), 37-55.

Rizq, R. (2012a). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice*, 18(1), 7-24.

Rizq, R. (2012b). The ghost in the machine: IAPT and organizational melancholia. *British Journal of Psychotherapy*, 28(3), 319-335.

Rizq, R. (2013). IAPT and thoughtcrime: Language bureaucracy and the evidence-based regime. *Counselling Psychology Quarterly*, 28(4), 111-115.

Rizq, R., Hewey, M., Salvo, L., Spencer, M., Varnaseri, H., & Whitfield, J. (2010). Reflective voices: Primary care mental health workers' experiences in training and practice. *Primary Healthcare Research & Development*, 11(01), 72-86.

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, 11(1), 25-41.

Robinson, S., Kellett, S., King, I., & Keating, V. (2012). Role transition form mental health nurse to IAPT high intensity psychological therapist. *Behavioural and Cognitive Psychotherapy*, 40(3), 351–366.

Robson, C. (2011). *Real World Research* (3rd Ed.). Chichester: Wiley.

Rodgers, M., Asaria, M., Walker, S., McMillan, D., Lucock, M., Harden, M., ... & Eastwood, A. (2012). The clinical effectiveness and cost-effectiveness of low-intensity psychological interventions for the secondary prevention of relapse after depression: A systematic review. *Health Technology Assessment*, 16(28), doi: 10.3310/hta16280.

Rolfe, G., Freshwater, D., & Jasper, M. (2001). *Critical reflection for nursing and the helping professions: A user's guide*. Basingstoke: Palgrave Macmillan.

Roth, A. D. & Pilling, S. (2008). Using an evidence-based methodology to identify the competencies required to deliver effective cognitive and behavioural therapy for

depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 36, 129–147.

Rowland, N. (2007). *Evidence submitted by the British Association for Counselling and Psychotherapy (NICE 92) March 2007*. UK Parliament: Health Select Committee. Retrieved 7th August 2014 from: http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/503/503we18.htm.

Ryan, T. A., Bailey, A., Fearon, P., & King, J. (2013). Factorial invariance of the patient health questionnaire and Generalized Anxiety Disorder Questionnaire. *British Journal of Clinical Psychology*, 52(4), 438-449.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *BMJ*, 312(7023), 71.

Sainsbury Centre for Mental Health (2005) *The Neglected Majority: Developing Intermediate Mental Healthcare in Primary Care*. London: The Sainsbury Centre for Mental Health.

Sainsbury, R., Irvine, A., Aston, J., Wilson, S., Williams, C. & Sinclair, A. (2008). *Mental Health and Employment, DWP Research Report 513*. London: Department for Work and Pensions.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. (2015). Exploring Professional Help-Seeking for Mental Disorders. *Qualitative Health Research*, 1049732315591483.

Savin-Baden, M., & Major, C. H. (2013). *Qualitative research: The essential guide to theory and practice*. Oxon: Routledge.

Scanlon, C., & Adlam, J. (2010). The Recovery Model or the modelling of a cover-up? *Groupwork*, 20(3), 100-114.

Scanlon, C., & Adlam, J. (2013). Knowing your place and minding your own business: On perverse psychological solutions to the imagined problem of social exclusion. *Ethics and Social Welfare*, 7(2), 170–183.

Schoenwald, S. K., Garland, A. F., Chapman, J. E., Frazier, S. L., Sheidow, A. J., & Southam-Gerow, M. A. (2011). Toward the effective and efficient measurement of implementation fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 32-43.

Schoenwald, S. K., McHugh, R. K., & Barlow, D. H. (2012). The science of dissemination and implementation. In R. K. McHugh, & D. H. Barlow (Eds.)., *Dissemination and Implementation of Evidence-Based Psychological Interventions*. (p.16-42). New York: Oxford University Press.

Schön, D. (1987). *Educating the reflective practitioner*. San Francisco, CA: Jossey-Bass.

Scott, H. (2010). The medical model: The right approach to service provision? *Mental Health Practice*, 13(5).

Seward, J. & Clark, M. (2010). Establishing the Improved Access to Psychological Therapies Programme: Lessons from large-scale change in England. In J. Bennett-Levy, D. Richards, P. Farrand, H. Christensen, K. Griffiths, D. Kavanagh, … & B. Klein (Eds)., *Oxford Guide to Low Intensity CBT Interventions* (p.479-486). Oxford: Oxford University Press.

Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., ... & Wilson, G. T. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy*, 47(11), 902-909.

Shankland, J., & Dagnan, D. (2015). IAPT practitioners' experiences of providing therapy to people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities*, 9(4), 206-214.

Sharp, A., Dickson, R., & Whittington, R. (2014). The Improving Access to Psychological Therapies programme in Bolton, UK: A qualitative realist analysis. *The Lancet*, 384, S71.

Shepherd, M., & Rosairo, M. (2008). Low-intensity workers: Lessons learned from supervising primary care mental health workers and dilemmas associated with such roles. *Mental Health in Family Medicine*, 5(4), 237.

Shepherd, M. (2014). Do primary care psychological therapists 'think family'? Challenges and opportunities for couple and family therapy in the context of 'Improving Access to Psychological Therapies'(IAPT) services. *Journal of Family Therapy*, 36(1), 39-61.

Shimizu, E. (2010). Collaboration between psychiatrists and clinical psychologists for efficient delivery of cognitive behavioral therapy in Japan. *Seishin shinkeigaku zasshi= Psychiatria et neurologia Japonica*, 113(4), 405-410.

Shimokawa, K., Lambert, M. J., & Smart, D. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting & Clinical Psychology*, 78, 298-311.

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist*, 34(1), 20-23.

Small, M. L. (2009). 'How many cases do I need?' On science and the logic of case selection in field-based research. *Ethnography*, 10(1), 5–38.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2013). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications.

Sokolowski, R. (2000). *Introduction to phenomenology*. Cambridge: Cambridge University Press.

Spielmans, G. I., Berman, M. I., & Usitalo, A. N. (2011). Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. *The Journal of Nervous and Mental Disease*, 199(3), 142-149.

Spitzer, R.L., Kroenke, R., Williams, J.B. & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166, 1092–1097.

Spratt, C. G., & Carey, T. A. (2009). Can a control model approach assist case formulation in psychotherapy? *The Cognitive Behaviour Therapist*, 2(03), 197-210.

Spring, B. (2007). Evidence-based practice in clinical psychology: What it is, why it matters; what you need to know. *Journal of Clinical Psychology*, 63(7), 611-631.

Sreeharan, V., Madden, H., Lee, J. T., Millett, C., & Majeed, A. (2013). Improving Access to Psychological Therapies and antidepressant prescribing rates in England: A longitudinal time-series analysis. *British Journal of General Practice*, 63(614), e649-e653.

Stanton, E. (2012). Ensuring ill health is not all in the mind. Beacon UK. *Health Service Journal*. Retrieved 15th September 2014 from: http://beaconhs.co.uk/wp-content/uploads/HSJ-IAPT-Article.pdf.

Steel, C., MacDonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: Burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health*, 24(1), 33-37.

Steinert, C., Hofmann, M., Kruse, J., & Leichsenring, F. (2014). Relapse rates after psychotherapy for depression - stable long-term effects? A meta-analysis. *Journal of Affective Disorders*, 168C, 107–118.

Stern, J., Hard, E., & Rock, B. (2015). Paradigms, politics and pragmatics: Psychotherapy in primary Care in City and Hackney–a new model for the NHS: Part 1: The historical, political and economic drivers behind the creation of the service. *Psychoanalytic Psychotherapy*, (ahead-of-print), 1-22.

Stetler, C. B., Legro, M. W., Wallace, C. M., Bowman, C., Guihan, M., Hagedorn, H., ... & Smith, J. L. (2006). The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine*, 21(S2), S1-S8.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine*, 38(5), 677-688.

Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings. *Psychological Medicine*, 36(04), 555-566.

Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*, 15(2), 113.

Thomas, M., & Drake, M. (Eds.). (2012). *Cognitive Behaviour Therapy Case Studie*s. London: SAGE Publications.

Thornicroft, G., & Tansella, M. (2005). Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiologia e Psichiatria Sociale*, 14(1), 1-3.

Turner, J. (2015). *Telephone versus face-to-face psychological therapy in an improving access to psychological therapies (IAPT) low-intensity service: An exploration of practitioners' and patients' experiences and its effectiveness*. Doctoral dissertation: University of Southampton.

Turpin, G., & Fonagy, P. (2010). *New Ways of Working for Psychological Therapists: WORKSTREAM ONE - The Evidence base for Psychological Therapies: Implications for Policy and Practice*. The National Institute for Mental Health in England (NIMHE) National Workforce Programme. Retrieved from: www.iapt.nhs.uk.

Turpin, G. & Wheeler, S. (2011). *IAPT Supervision Guidance. Revised March 2011. Improving Access to Psychological Therapies*. Retrieved from: www.iapt.nhs.uk.

Twomey, C., O'Reilly, G., & Byrne, M. (2015). Effectiveness of cognitive behavioural therapy for anxiety and depression in primary care: A meta-analysis. *Family Practice*, 32(1), 3-15.

Unsworth, G., Cowie, H., & Green, A. (2012). Therapists' and clients' perceptions of routine outcome measurement in the NHS: A qualitative study. *Counselling and Psychotherapy Research*, 12(1), 71-80.

Vail, L., Adams, A., Gilbert, E., Nettleingham, A., & Buckingham, C. D. (2012). Investigating mental health risk assessment in primary care and the potential role of a structured decision support tool, GRiST. *Mental Health in Family Medicine*, 9(1), 57–67.

van Straten, A., Hill, J., Richards, D. A., & Cuijpers, P. (2015). Stepped care treatment delivery for depression: A systematic review and meta-analysis. *Psychological Medicine*, 45(02), 231-246.

Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counselling Psychology*, 56(2), 301.

Waddell, G. & Burton A. K. (2006). *Is Work Good for your Health and Well-being?* London: The Stationery Office.

Wagner, S. M., Rau, C., & Lindemann, E. (2010). Multiple informant methodology: A critical review and recommendations. *Sociological Methods & Research*, 38(4), 582-618.

Waller, R., & Gilbody, S. (2009). Barriers to the uptake of computerized cognitive behavioural therapy: A systematic review of the quantitative and qualitative evidence. *Psychological Medicine*, 39(5), 705.

Walker, C. (2012). Personal debt and cognitive delinquency: Neoliberal constructions of financial inadequacy in the UK. *Journal of Community and Applied Social Psychology*, 22, 533-538.

Walklet, E., & Percy, C. (2014). Stress and coping in IAPT staff: A mixed methods study. *Applied Psychological Research Journal*, 1(2), 15-25.

Watts, C. & Robjant, K. (2008). Positive mental health promotion amongst the Tamil community: The development of a community-led model. *Clinical Psychology Forum*, 193, 39–42.

Weinstein, J. (2010). *Mental health, service user involvement and recovery*. London: Jessica Kingsley Publishers.

Westen, D., Novotny, C. A., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130(4), 631-663.

Wesson, M., & Gould, M. (2010). Can a "return-to-work" agenda fit within the theory and practice of CBT for depression and anxiety disorders? *The Cognitive Behaviour Therapist*, 3(1), 27–42.

Westra, H. A., Aviram, A., Barnes, M., & Angus, L. (2010). Therapy was not what I expected: A preliminary qualitative analysis of concordance between client expectations and experience of cognitive–behavioural therapy. *Psychotherapy Research*, 20(4), 436-446.

Wilczynski, N. L., Haynes, R. B., & Hedges Team. (2007). EMBASE search strategies achieved high sensitivity and specificity for retrieving methodologically sound systematic reviews. *Journal of Clinical Epidemiology*, 60(1), 29-33.

Wiley, J. (Eds.). (2012). *Theory and Practice in the Philosophy of David Hume* (p.1-27). Basingstoke: Palgrave MacMillian.

Wilkinson, R. & Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Allen Lane.

Williams, C. H. J. (2015). Improving Access to Psychological Therapies (IAPT) and treatment outcomes: Epistemological assumptions and controversies. *Journal of Psychiatric and Mental Health Nursing*, 22(5), 344-351.

Williams, J., Leamy, M., Bird, V., Harding, C., Larsen, J., Le Boutillier, C., ... & Slade, M. (2012). Measures of the recovery orientation of mental health services: Systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 47(11), 1827-1835.

Wittchen, H. U., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., ... & Steinhausen, H. C. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. *European Neuropsychopharmacology*, 21(9), 655-679.

Wolpert, M. (2014). Uses and Abuses of Patient Reported Outcome Measures (PROMs): Potential iatrogenic impact of PROMs implementation and how it can be mitigated. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(2), 141-145.

WHO. (2008a). *Integrating mental health into primary care: A global perspective*. World Organization of National Colleges, Academies, & Academic Associations of General Practitioners/Family Physicians. Geneva: World Health Organization.

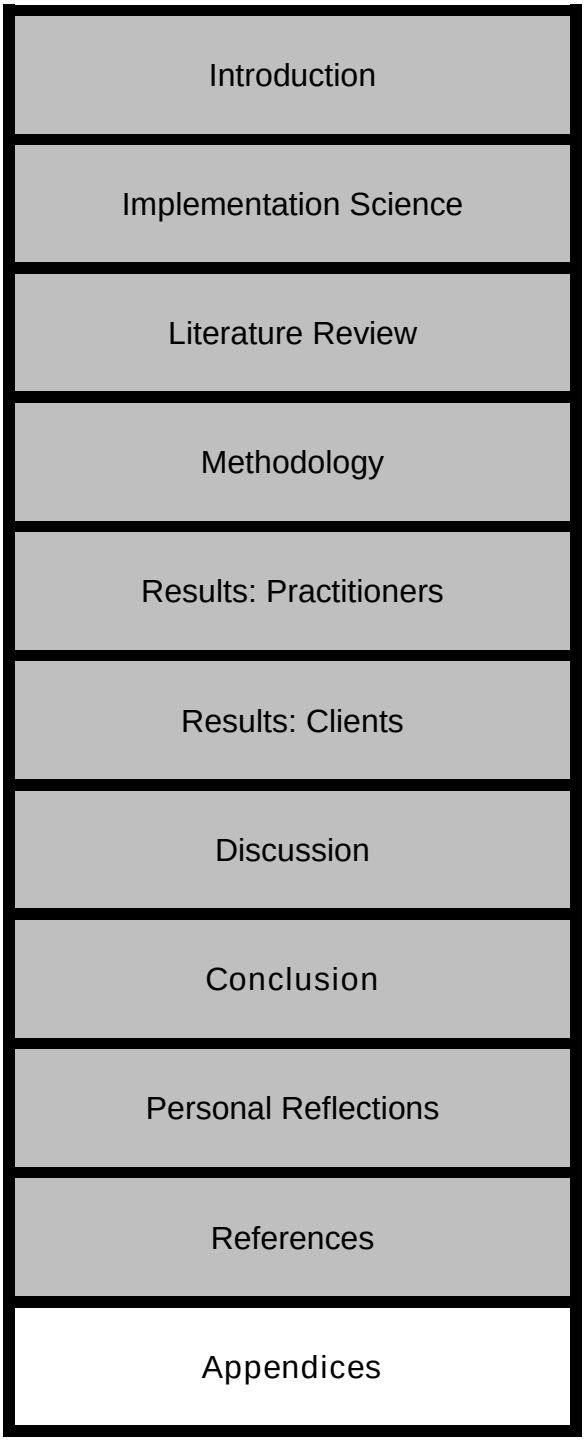
WHO. (2008b). *The World Health Report 2008: Primary healthcare. Now more than ever*. World Organization of National Colleges, Academies, & Academic Associations of General Practitioners/Family Physicians. Geneva: World Health Organization.

Wykes, C. (2013). *Are gains made in IAPT psychoeducational groups maintained over time? A qualitative study*. Professional doctorate thesis: University College London.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health*, 15(2), 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith, (2nd Ed.), *Qualitative psychology: A practical guide to methods* (pp.235–251). London: SAGE Publications.

Youn, S. J., Kraus, D. R., & Castonguay, L. G. (2012). The Treatment Outcome Package: Facilitating practice and clinically relevant research. *Psychotherapy*, 49, 115-122.


Introduction
Implementation Science
Literature Review
Methodology
Results: Practitioners
Results: Clients
Discussion
Conclusion
Personal Reflections
References
Appendices

11 Appendices

11.1 Recruitment

11.1.1 Email Recruitment: Practitioner Group

Faculty of Health and Social Care
Centre for Psychological Therapies in Primary Care
P.O. Box 4813
Shrewsbury
SY1 9JU
: 01743 341 739
cptpc@chester.ac.uk

UNDERSTANDING THE PROCESSES INVOLVED WITH IMPLEMENTING AN IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES SERVICE

Dear XXXX,

My name is Scott Steen and I am currently a PhD student studying within the Centre for Psychological Therapies in Primary Care, based at the University of Chester. As part of my main research project I am aiming to interview key members of staff within the Improving Access to Psychological Therapies (IAPT) programme. The study's objectives will aim to compare a select number of service models within the IAPT programme, contrasting how each model is implemented and its subsequent effects on the outcomes of the service.

This research seeks to take advantage of an opportunity in comparing the IAPT service sites XXXX. The Trust delivers IAPT adult services over a number of locations, and I would be incredibly appreciative if I could meet with you in order to discuss the research aims and methodology further, and indeed the plausibility of your potential participation in this research.

I am seeking to interview key stakeholders within the IAPT sites of interest in order to evaluate and report on the healthcare model in use. The study aims to explore the patient pathway through the use of semi-structured interviewing in order to report on effective innovations within that model. I am aiming to conduct a total of 1 or 2 interviews, projected to take 45 minutes to 1 hour in duration, with a clinical lead/practitioner and as well as a key member of the administrative staff at each site, where possible. The questions will centre around healthcare modelling in respect to referral/access, assessment, therapy assignment/engagement, therapist training/supervision and outcomes of the service. All responses will be treated with the strictest degree of confidence.

The proposed study has been granted ethical approval from the Faculty of Health and Social Care Ethics Committee, University of Chester [Ref: S-HSC021013], as well as approval from the South Staffordshire and Shropshire Foundation Trust R&D department. The University of Chester will be acting as sponsor to this research project.

Would it be possible to arrange an appointment with yourself in respect to this? Also is there a member of your administrative team that could be of help? If you are unable to help me, would you be able to put me in contact with another member of staff. I am intending to conduct the interview face-to-face but I am happy to do it over the phone for your convenience if necessary. My contact details are below if you wish to discuss this further. This is the best email to catch me on. If you would like to see the interview framework/questions beforehand please let me know.

Thank you for taking the time to read this as I hope it is the first of a valuable correspondence between us. My primary contact details are listed below, and contacts details for the Centre can be found in the letterhead. Can you please respond to this email so I can ensure you are in receipt of it, and possibly inform me of a convenient time for us to discuss your service's potential participation in the proposed research.

Yours sincerely,

Scott Steen
Research Student
The Centre for Psychological Therapies in Primary Care
University of Chester
1224282@chester.ac.uk

11.1.2 Email Recruitment Follow-Up Regarding Second Study Participation to IAPT Services

Dear XXXX,

You recently agreed to take part in an interview regarding my research project, discussing the IAPT programme and its delivery at your site. I trust you remember. I am now emailing today with respect to a follow-up phase to this to which I briefly spoke with you about. I am seeking to recruit and interview ex-patients of the IAPT service to report on their experiences. As I am sure you will agree, it is important in all walks of research to report on the patients' voice and provide them with the platform to engage with their health service.

For this phase, I have been collaborating with the University of Chester and the XXXX– a support group charity for mental health service-users. It has received ethical approval from the University ethics committee, XXX R&D office, and finally an independent NHS ethics committee (also attached for your consideration Ref: 14/NW/0295). The University of Chester will also be acting as the sponsor for this project.

The time has now come for me to ask formally for your support in this part of my research study. Would it be possible to meet and discuss with yourself the possibility of your engagement with this phase of the project? An initial plan I had in mind would be to ask you, or your staff, to offer the participant information sheet and study advertisement sheet, as well as a reply slip, to patients who are coming to an end of their treatment, or possibly in a follow-up group, or session you may have with individuals. Those interested would then contact the Centre for Psychological Therapies at the University of Chester, to leave their contact details. This is to ensure there is no prior access to confidential information, and only those interested will be contacted further. This is just an initial plan I had considered, but I realise you may have your own comments or considerations to make for this type of recruitment, and would be happy to discuss this with yourself.

I am aiming to conduct these interviews at the University, in a privately booked room, or over the phone. Participants would be reimbursed for any travel they make. If a participant requested it to be closer to home, I may seek to ask for a room booking at your premises, but this can be discussed prior to, and on a case-by-case basis. However, this is not essential. XXXX will also be overseeing this part of the research project in case participants have any concerns and wish to seek support and advice from an independent body. You will also see from the study materials that there is a support network in place, which has received approval and comments from various health bodies.

You will be informed when I have come to the end of this, and also receive progress reports along the way to keep you informed. The interviews will last around 45 minutes to 1 hour in duration, and I will not be asking them to discuss the status of their mental health, but rather their engagement with the IAPT service.

Please take a look at the study materials I have attached to this email, and let me know if there is anyway your site would be able to participate. My primary contact details are below, and I would be grateful for any early indication of your willingness to participate.

Yours sincerely,

Scott Steen

Research Student
The Centre for Psychological Therapies in Primary Care
University of Chester
1224282@chester.ac.uk

11.1.3 Study Advertisement: Client Group

Exploring the Lived Experiences of the IAPT Programme: A Study Investigating Client Narrative

University of Chester

Introduction

The University of Chester and XXX are formally asking for your support and participation in the evaluation of mental healthcare within the NHS. Specifically, the main investigator wishes to discuss with individuals, their views and experiences on the improving Access to Psychological Therapies (IAPT) programme. If you have been referred for psychological therapy within the NHS and wish to express your views and experiences then please get in contact. The study is seeking to conduct a series of interviews where you will be able to share, in confidence, your experiences.

What will I be asked to do if I agree to take part?

If you decide to take part, then you will be invited for an interview at a time that is convenient for you, at the University of Chester premises. It is intended to last about 45 minutes to 1 hour in duration and you will be reimbursed for any travel you make (pending proof of receipt). The interview will aim to explore your experiences within the IAPT programme, including what you think its main strengths and weaknesses are. The interview will not be asking about the status of your mental health. It will allow you a safe, convenient and confidential opportunity to share your experiences of psychological therapy within the NHS.

If you wish you take part but are unable to make a face-to-face interview then you can participate over the phone. Audio recording is intended but it is not essential and you can opt out of this.

Will my data be Confidential?

Your contribution will be anonymised and any identifying markers will be removed. Your data will be treated in accordance with the Data Protection Act (1998). You will retain your right to withdraw at any time.

I would be very grateful for an early indication of your willingness to contribute to this research. Please take a slip of the contact details below and get in contact via the email or phone number detailed below. Alternatively, please complete a reply slip attached to this and the main investigator will make contact with you to discuss your possible participation.

Contact Information

If you are interested in taking part in this and would like further information about the research aims, please get in contact with the lead researcher (details below), or fill out the reply form and hand it in to your nearest service contact, email or post. Also attached is the participant information sheet for your consideration.

Scott Steen
The Centre for Psychological Therapies in Primary Care
1224282@chester.ac.uk
01743 341 739

11.2 Participant Information Sheet

11.2.1 Practitioner Group

University of Chester
Faculty of Health and Social Care
Centre for Psychological Therapies in Primary Care
P.O. Box 4813
Shrewsbury
SY1 9JU

RESEARCH PROJECT: Understanding the Processes Involved with Implementing an Improving Access to Psychological Therapies Service

Introduction

Thank you for taking the time to read this participant information sheet. The aim of this investigation is to report on and evaluate this site's model of service provision for the Improving Access to Psychological Therapies (IAPT) programme. This will centre on questioning related to client access, involvement and subsequent departure from the service. The purpose of this interview is to explore your experiences in the implementation and operation of services. Your participation is greatly appreciated and may benefit future clients accessing the programme.

What will I be asked to do if I agree to take part?

The method of data collection will take the form of a semi-structured interview. This is intended to take 45 minutes to 1 hour in duration. The interview is composed of 6 main areas; referral/access, assessment, therapy assignment/engagement, therapist training/supervision and outcomes of the service. The main purpose is to develop an ongoing dialogue exploring the rationale and potential impact of these developments of both staff and clients.

Will my data be Confidential?

All responses will be treated with the highest confidentiality. Any identifying information will be removed and the responses you give will be heavily anonymised. Your data will be treated in accordance with the Data Protection Act (1998). The interview will be audio-recorded for reliability purposes only and these will be destroyed once full data collection is complete. If you would rather the audio wasn't recorded, please make the researcher aware of this.

Do I have to take part?

If you decide now or at any point to withdraw your consent or stop participating, you are free to do so at no penalty to yourself. You are also free to skip specific questions and continue participating at no penalty. You will not have to state a reason for this.

If you wish to contact someone in case of a complaint, please contact:

Dr Annette McIntosh-Scott (Executive Dean - Faculty of Health and Social Care):
Direct Line: 01244 513386 / Email: a.mcintosh@chester.ac.uk

IF YOU REQUIRE MORE INFORMATION ABOUT THIS STUDY, PLEASE FEEL FREE TO ASK THE RESEARCHER BEFORE CONSENTING.

University of Chester

Faculty of Health and Social Care
Centre for Psychological Therapies and Primary Care
P.O. Box 4813
Shrewsbury
SY1 9JU

Exploring the Lived Experiences of the IAPT Programme: A Study Investigating Client Narrative

Introduction

Thank you for taking the time to read this information sheet. This is a project that is looking to talk with you about your experiences of the Improving Access to Psychological Therapies (IAPT) Programme. The IAPT programme is a method of care delivery, within the NHS, for delivering psychotherapy. The main researcher wishes to discuss what it is like to access, engage with, and leave an IAPT service. This project is being done for an educational qualification. Your responses may help to improve future care within this area.

What will I be asked to do if I agree to take part?

The interview is intended to last about 45 minutes to 1 hour in duration, and will aim to explore your experiences within the IAPT programme, including what you think is good or bad about it. This will be reflected in the questioning. The interview will not be asking about the status of your mental health. The areas of interest will include discussing the ease of access, process, and conclusion with the service, as well as what you found were the most and least satisfying aspects of the programme. It will allow you a safe, convenient and confidential opportunity, to share your experiences of the delivery of psychological therapy within the NHS.

The interviews are intending to take place at the University of Chester premises, in a privately booked room. You will be reimbursed for travel, pending proof of receipt from a train or bus fare. Those driving will be reimbursed at a rate of £0.40p per mile. If you would prefer, this interview may be able to take place at your local therapy centre. This will be done on a case-by-case basis and will need approval from these premises, which the lead researcher will organise. Alternatively, you can conduct this interview over the phone for your own convenience.

Why is this information being sought?

The basis for conducting an interview is to gain on a deeper understanding, as to what are the experiences of psychological therapies in the NHS. The project will also serve to provide a voice for those involved in the IAPT programme and identify areas requiring urgent attention.
&

What will happen to my responses and how will this help?

Your responses will be collected and pooled into a series of several other participant responses taking part in the project. This will then be used to search for themes and patterns across each individual experience. At the end of the study, all recordings will be destroyed, and transcripts will be retained for analysis. Once a full write-up is complete, these transcripts will be destroyed. You will be given access to a final project report.

Will my data be Confidential?

Your contribution today will be anonymised and any identifying markers will be removed. The handling of information complies with the NHS Research Governance Framework for Health & Social Care (2005), Data Protection Act (1998) and the BACP (2013) ethical framework for good practice.

The interview will be audio-recorded for reliability purposes only and these will be destroyed once full data collection is complete. If you would rather the audio wasn't recorded, please make the researcher aware of this.

Your information will not be passed on to anyone else without your expressed consent unless there are exceptional circumstances in which the health and safety of yourself or others is at risk, or when the law requires the information to passed forward. Should the emergence of poor clinical practice become evident then, pending your consent, the lead researcher will contact the appropriate services to follow this up. You will be informed of this, and it can either be submitted anonymously, or along with your name, depending on what you choose.

Do I have to take part?

If you decide now or at any point to withdraw your consent or stop participating, you are free to do so at no penalty to yourself. You are also free to skip specific questions and continue participating at no penalty.

If you wish to contact someone in case of a complaint, please contact:
Dr Annette McIntosh-Scott (Executive Dean - Faculty of Health and Social Care):
Direct Line: 01244 513386 / Email: a.mcintosh@chester.ac.uk

Where can I seek further support and advice?

If you become distressed, concerned or require any further information there are a range of resources available:

Inclusion Matters (Talking Therapies Service)
Liverpool: 0151 228 2300
Wirral: 0151 514 2556
Sefton: 0151 955 3200

North Staffordshire Wellbeing Service
01782 711651

Mind Charity
15-19 Broadway, Stratford, London E15 4BQ
T: 020 8519 2122, F: 020 8522 1725
e: contact@mind.org.uk

Shropshire Independent Advocacy Scheme Ltd
01743 361702
e: enquiries@siasonline.org

Counselling Directory
http://www.counselling-directory.org.uk
0844 8030 240

SS&SFT Patient Liaisons Service
(*for information about specific services, comments, compliments or complaints*)
Email: **pals@sssft.nhs.uk**

If you require more information about this study, please feel free to ask the researcher before consenting.

If you would like a copy of this information sheet as an audio cassette or in Braille, large print or other languages, please contact Lee Good on 01743 341739 and she will do her best to help.

11.3 Client Consent to be Contacted: Reply Form

University of Chester
Faculty of Health and Social Care
Centre for Psychological Therapies in Primary Care
P.O. Box 4813
Shrewsbury
SY1 9JU
01743 341 739
: cptpc@chester.ac.uk

Exploring the Lived Experiences of the IAPT Programme: A Study Investigating Client Narrative

REPLY FORM

Please send the completed form "For the Attention of Scott Steen" to:
1224282@chester.ac.uk OR cptpc@chester.ac.uk
(or post to FAO Scott Steen, Centre for Psychological Therapies in Primary Care, PO Box 4813, Shrewsbury, SY1 9JU).

Or you can contact the Centre for Psychological Therapies in Primary Care on: 01743 341739.

Alternatively, you can hand this in to your nearest IAPT service and the lead researcher will get in contact with you to discuss the research aims and objectives.

Please complete as appropriate:

I would like to meet and discuss the possibility of me taking part in the research study entitled: "Exploring the Lived Experiences of the IAPT Programme: A Study in Investigating Client Narrative"

☐ Please tick here if so.

Name	
Contact Details:	
Preferred contact method and time Do you require any specific access or support assistance?	

11.4 Consent Form

11.4.1 Practitioner Group

University of Chester

Title of Project: Understanding the Processes Involved with Implementing an Improving Access to Psychological Therapies Service

Name of Researcher: Scott Steen

		Please Initial Box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected.	☐
3.	I agree to have my responses audio-recorded for the purposes of this interview, and that some anonymised, direct quotes may be used in the future for the purposes of data reporting.	☐
4.	I agree to take part in the above interview.	☐

Name of Participant	Date	Signature
Researcher	Date	Signature

11.4.2 Client Group

University of Chester

Title of Project: Exploring the Lived Experiences of the IAPT Programme: A Study Investigating Client Narrative

Name of Researcher: Scott Steen

		Please Initial Box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected.	☐
3.	I agree to have my responses audio-recorded for the purposes of this interview.	☐
4.	I agree that anonymised direct quotes may be used for subsequent reports and publications and understand that these will remain anonymous at all times.	☐
5.	I understand that data from the study may be looked at by regulatory authorities or by persons from the Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.	☐
5.	I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

11.5 Interview Schedule

11.5.1 Practitioner Group

Thank you for taking the time to engage with this project.

The purpose of this interview will aim to uncover and report on the implementation of the service model currently utilised within your site. It will seek to explore your experiences during the implementation process in order to gain an understanding behind what is influential during the implementation process. I hope to develop a dialogue with you that will explore the rationale and potential impact of these developments.

Key:

Main Section:

Prompt questions

1. What is the protocol for **referral and access** to this service and why has this been implemented?

   Do you engage in any community engagement or liaisons? What proportion of referrals are self-referrers, from GPs?, other sectors? How did you find the initial setting up of this pathway? What influenced your decision to implement in this way?

2. Can you tell me about the process for **assessing** clients and what influences the implementation process for this?

   How is person assessed for treatment? What are the exclusion/inclusion criteria? What are the biggest constraints? What impacts on your decision to implement this procedure?

3. Next I would like to explore the **engagement** of clients, how does the service conduct and encourage engagement with the model?

   How are the outcome measures utilised in therapy? In what locations do you provide your services, and what is the dominant location chosen? How has the service sought to reduce dropout? What special adjustments are available? What do you perceive as being the biggest influence on service engagement? How does the implementation process effect or is effected by client engagement?

4. What is the model for **training and supervision** at this service what are your experiences of trying to implement this?

5. What happens in the final stages of your service in terms of **outcome**?

   What is the protocol for leaving the service? Is there any follow-up framework in place, or ongoing support? Are there any relationships with other agencies? How is the service performance handled? How do you personally judge when someone is recovered? How, if at all, have outcomes influenced the implementation process and your experience in the provision of services?

6. Finally, I would like to ask about any ongoing **service development** this service may have been or still is involved in, and what the rationale was behind these innovations?

   Is there anything, which has changed since the initial implementation of the site? How and why did this change? What do you find is the most influential factor in determining the client engagement and outcome with the service? What components do you find are the beneficial/wasteful? How has the implementation process developed in response to client feedback and outcome monitoring?

7. Looking back, are there any changes you would have made or attempted to make with regards to IAPT service provision, knowing what you know now?

8. Is there anything that hasn't been mentioned that you would like to draw attention to of the programme?

11.5.2 Client Group

This interview seeks to discuss your experiences of psychological therapy within the NHS, in particular the Improving Access to Psychological Therapies (IAPT) programme to which you have engaged in. By exploring your lived experience of the programme, including what you found beneficial and what you found wasteful, the research aims to uncover what the model was like for you in catering to your needs and supporting your care. Your valuable insight will help evaluate and possibly shape future service provision.

Key:

Main Section

prompt questions

1. What were your experiences of **accessing** the service?
   inc. waiting times, ease of access, sufficient information, what influenced accessing the service?

2. How did you find the process of **assessment**, and what did that involve?
   inc. ongoing support, felt understood/misunderstood, offered choice

3. How did you find **engaging** with the service? What was most important to you in terms of staying engaged?
   inc. location, timings, missed appointments, form of therapy i.e. phone/face-to-face, thoughts of outcome measuring, therapist relationship, perception of the therapy, any external factors influencing engagement, how flexible?

4. How did you **complete** your therapy and how did this make you feel?
   inc. was there a contract in place, or a gradual downsize of therapy delivered? how outcomes were judged, whether you had any say in its termination, any ongoing support in place or in use; what were your experiences beyond leaving the service

5. What advice/information would you give to new referrals coming into the programme? What advice would you have liked to hear?

6. What were the most and least satisfying aspects to being involved with the IAPT programme?
   Pre/During/Post. What would you like to change or stay the same?

7. How did your relationship with your therapist/contact influence your time with the programme and what was your experience of this?

8. How do you feel the programme catered to your individual needs and circumstances?

9. Is there anything that hasn't been mentioned that you would like to draw attention to of the programme? Or that impacted your course of treatment with IAPT?

11.6 Participant Characteristics

11.6.1 Practitioner Group

Pseudonym	Type of Service	Background	Age (yrs)	Gender	Ethnicity
"Daniel"	IAPT	CBT	45-54	Male	White British
"Melissa"	IAPT	CBT	45-54	Female	White British
"Isabelle"	IAPT	CBT	35-44	Female	White British
"Kevin"	IAPT	CBT	35-44	Male	White British
"Rebecca"	IAPT-light	Counselling	35-44	Female	White British
"Chris"	IAPT-light	Counselling	45-54	Male	White British
"Gemma & Mary"	IAPT	CBT and Counselling	35-44 & 45-54	Female	White British

11.6.2 Client Group

Pseudonym	Time since Therapy Finished	Type of Therapy Received	Employment Status	Age (yrs)	Gender	Ethnicity
"Rachel"	2 weeks	Group-based CBT	Student	16-24	Female	White British
"Michelle"	1 month	Face-to-face CBT (Step-2)	Retired	55-64	Female	White British
"Sarah"	1 month	Face-to-face CBT & Group-based CBT (Step-2)	Employed, Part-time	55-64	Female	White British
"Kate"	2 weeks	Psycho-educational group	Unemployed	35-44	Female	White British
"Maria"	1 month	Face-to-face CBT (Step-3)	Unemployed	44-55	Female	British Asian
"Trevor"	-	To commence	Employed, Full-time	44-55	Male	White British
"Felicity"	2 weeks	Group-based CBT	Self-employed, Full-time	44-55	Female	White British

11.7 Community Mental Health Profiles

According to Public Health England Community Health Profile indicators (2015).

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Risk and Related Factors	Socioeconomic deprivation: overall IMD score	2012	21.5	5.8	47.4	23.9	16.4	30.8	43.1	18.4	15.5	18.7
	Older people living in income deprived households: % of people over 60	2012	18.10%	7.40%	56.20%	22.2%	15.6%	27.3%	36.9%	16.0%	16.5%	15.30%
	People with CHD and/or diabetes: % patients on the GP register	2012/13	7.30%	4.30%	10.40%	7.3%	7.7%	8.3%	7.5%	8.6%	7.8%	7.60%
Prevalence	People estimated to have any common mental health disorder: Estimated % of population aged 16-74	2014/15	15.62%	10.29%	25.51%	14.20%*	10.29%*	21.62%*	23.95%*	12.69%*	11.49%*	11.39%*
	Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2013/14	6.50%	3.10%	12.40%	9.6%	6.9%	7.5%	7.1%	7.3%	6.6%	6.00%
	New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2013/14	1.10%	0.50%	2.10%	1.4%	1.1%	1.0%	1.1%	1.7%	1.1%	1.00%
	Long term mental health problems among GP survey respondents: % people completing GP patient survey who report long-term mental health problem	2013/14	4.80%	2.50%	10.30%	6.1%	4.1%	5.7%	7.8%	4.5%	4.6%	4.10%
	Depression and anxiety among GP survey respondents: % of people completing GP patient survey reporting they feel moderately or extremely anxious or depressed	2013/14	12.10%	7.20%	19.40%	14.2%	10.29%	15.2%	18.5%	12.9%	10.7%	10.80%

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Services	Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2013/14	6.50%	3.10%	12.40%	9.6%	6.9%	7.5%	7.1%	7.3%	6.6%	6.00%
	New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2013/14	1.10%	0.50%	2.10%	1.4%	1.1%	1.0%	1.1%	1.7%	1.1%	1.00%
	Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU	2013/14	1.2	0.5	1.8	1.4	1.2	1.5	1.7	1.4	1.1	1.1
	Use of '1st choice' antidepressants: % of prescription items that were '1st choice' generic SSRIs	2013/14	63.50%	53.90%	74.60%	67.2%	65.1%	61.2%	60.3%	61.9%	67.1%	64.50%
	Hypnotics prescribing: Average daily quantities (ADQs) per STAR-PU	2013/14	1.16	0.53	2.21	1.22	1.10	1.28	1.46	1.19	0.82	0.94
	IAPT referrals: Rate (quarterly) per 100,000 population aged 18+	2014/15 Q2	694	154	1,853	764	382	1,155	926	685	367	446
	IAPT referrals for depression: Rate (quarterly) per 100,000 population aged 18+	2014/15 Q2	82	2	839	104	12	260	237	109	*	*
	IAPT referrals for mixed anxiety and depression: Rate (quarterly) per 100,000 population aged 18+	2014/15 Q2	91	2	1,050	23	28	51	30	9	*	*
	IAPT used by BME groups: % of referrals (in quarter) which are for people of black and minority ethnic groups	2014/15 Q2	16.40%	0.60%	75.10%	3.8%	2.0%	2.0%	10.6%	1.6%	*	3.10%

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Services	IAPT ethnic group coding completeness: % of referrals (in quarter) with a valid ethnic group code	2014/15 Q2	75.10%	10.10%	98.80%	67.2%	80.0%	84.3%	87.0%	52.1%	61.4%	74.70%
	Access to IAPT services: People entering IAPT (in month) as % of those estimated to have anxiety/depression	Sep-14	13.20%	0.40%	53.40%	16.5%	12.2%	11.9%	11.4%	19.4%	7.3%	15.70%
	Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+	2014/15 Q2	452	81	1,108	494	310	540	593	605	237	656
	Completion of IAPT treatment: Rate (quarterly) completing treatment per 100,000 population aged 18+	2014/15 Q2	271	33	567	332	217	461	334	265	33	133
	IAPT problem descriptor completeness: % (in quarter) of IAPT referrals with an ICD-10 code	2014/15 Q2	48.10%	0.00%	100%	32.8%	22.6%	44.4%	60.6%	41.6%	0.0%	0.00%
Quality and Outcomes	Assessment of depression: % of adults with a new diagnosis of depression who had a bio-psychosocial assessment on diagnosis	2013/14	75.80%	47.20%	90.20%	69.8%	75.6%	63.0%	60.7%	47.2%	70.3%	73.80%
	Review of depression: % of newly diagnosed patients with depression who had a review 10-35 days after diagnosis	2013/14	58.40%	33.80%	75.50%	58.4%	59.0%	48.3%	47.0%	51.1%	55.7%	53.90%
	Exception rate for depression: % of patients on depression register excluded from quality indicators	2013/14	20.70%	8.60%	37.30%	20.1%	17.6%	26.2%	31.3%	37.3%	22.4%	17.40%

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Quality and Outcomes	Support for people with LTCs: % of people with long term conditions visiting GP who feel they have had enough support from local services in last 6 months	2012/13	64.00%	54.30%	71.00%	64.1%	65.3%	66.4%	67.5%	64.4%	65.1%	63.70%
	Waiting < 28 days for IAPT: % of referrals (in month) waiting < 28 days for first treatment	Sep-14	64.70%	6.70%	100%	18.8%	85.1%	83.3%	94.5%	63.1%	17.4%	81.50%
	Waiting > 90 days for IAPT: % of referrals (in month) waiting > 90 days for first treatment	Sep-14	8.80%	-	-	33.3%	4.3%	*	*	13.8%	34.8%	3.70%
	IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Sep-14	45.00%	12.80%	91.70%	35.0%	42.9%	41.5%	35.0%	44.4%	33.3%	28.60%
	IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2014/15 Q2	63.50%	37.50%	78.60%	58.9%	61.2%	70.6%	63.6%	65.7%	42.9%	37.50%
	IAPT DNAs: % of IAPT appointments (in quarter) where patient did not attend and gave no advance warning	2014/15 Q2	12.50%	5.20%	35.80%	9.8%	8.9%	9.6%	10.2%	7.6%	12.4%	15.60%
	Patients finishing a course of treatment: % of patients entering IAPT service who receive a course of treatment	2014/15 Q2	45.90%	6.30%	97.80%	14.4%	25.8%	35.3%	23.9%	42.9%	34.1%	37.70%
	Paired data completeness: % of completed treatments (in quarter) with paired PHQ9 and ADSM scores	2014/15 Q2	96.50%	48.70%	100%	84.9%	90.7%	93.2%	85.1%	76.1%	58.3%	61.50%

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Finance	Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	£26,756	£14,296	£49,755	£24,322	£25,270	£30,920	£36,702	£26,948	£19,833	£19,833
	% spend on specialist mental health services: % of all secondary care services spend categorised as mental health (mapped from PCT)	2012/13	11.90%	8.10%	19.10%	10.8%	12.1%	11.7%	12.6%	11.9%	9.5%	9.50%
	Spend on other mental health services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	2012/13	£13,772	£3,903	£30,893	£17,574	£15,257	£11,125	£8,995	£12,210	£15,658	£15,658
	% spend on other mental health: % of all mental health spend categorised as other mental health (mapped from PCT)	2012/13	51.50%	13.10%	87.70%	72.3%	60.4%	36.0%	24.5%	45.3%	78.9%	78.90%
	Primary care prescribing spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	£857	-	-	£928	£976	£1,068	£1,133	£1,020	£870	£870
	Secondary Care Spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	£6,762	-	-	£4,343	£5,017	£2,105	£3,451	£6,239	£11,952	£11,952
	Community care spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	-	-	-	-	-	-	-	-	-	-
	Spend on Psychological Therapy Services (IAPT): rate (£000s) per 100,000 aged 16 64 (mapped from PCT)	2010/11	£487	-	-	£585	*	£943	£1,353	£914	*	*

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Finance	Spend on Psychological Therapy Services (Non-IAPT): rate (£000s) per 100,000 aged 16-64 (mapped from PCT)	2010/11	£534	-	-	£244	£1,396	£132	£396	£955	£251	£251
	Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly)	2014/15 Q1	£51.50	£20.90	£95.60	£54.8	£56.5	£65.2	£65.0	£65.3	£43.5	£50.40
	Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (£) per 1,000 STAR-PU (quarterly)	2014/15 Q1	£139.00	£54.70	£313.60	£145.3	£163.6	£108.0	£129.7	£146.6	£93.0	£104.60
Common Mental Health Disorder Pathway	Socioeconomic deprivation: overall IMD score	2012	21.5	5.8	47.4	23.9	16.4	30.8	43.1	18.4	15.5	18.7
	Long-term health problems or disability: % of people whose day-to-day activities are limited by their health or disability	2011	17.60%	11.20%	25.60%	18.6%	18.6%	22.9%	22.4%	20.9%	18.1%	17.60%
	People estimated to have any common mental health disorder: Estimated % of population aged 16-74	2014/15	15.62%	10.29%	25.51%	14.20%*	10.29%*	21.62%*	23.95%*	12.69%*	11.49%*	11.39%*
	Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2013/14	6.50%	3.10%	12.40%	9.6%	6.9%	7.5%	7.1%	7.3%	6.6%	6.00%
	New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2013/14	1.10%	0.50%	2.10%	1.4%	1.1%	1.0%	1.1%	1.7%	1.1%	1.00%
	Assessment of depression: % of adults with a new diagnosis of depression who had a bio-psychosocial assessment on diagnosis	2013/14	75.80%	47.20%	90.20%	79.70%	75.6%	63.0%	60.7%	47.2%	70.3%	73.80%

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Common Mental Health Disorder Pathway	Completion of IAPT treatment: Rate (quarterly) completing treatment per 100,000 population aged 18+	2014/15 Q2	271	33	567	332	217	461	334	265	33	133
	IAPT problem descriptor completeness: % (in quarter) of IAPT referrals with an ICD-10 code	2014/15 Q2	48.10%	0.00%	100%	32.8%	22.6%	44.4%	60.6%	41.6%	0.0%	0.00%
	Patients finishing a course of treatment: % of patients entering IAPT service who receive a course of treatment	2014/15 Q2	45.90%	6.30%	97.80%	14.4%	25.8%	35.3%	23.9%	42.9%	34.1%	37.70%
	Paired data completeness: % of completed treatments (in quarter) with paired PHQ9 and ADSM scores	2014/15 Q2	96.50%	48.70%	100%	84.9%	90.7%	93.2%	85.1%	76.1%	58.3%	61.50%
	IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Sep-14	45.00%	12.80%	91.70%	35.0%	42.9%	41.5%	35.0%	44.4%	33.3%	28.60%
	IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2014/15 Q2	63.50%	37.50%	78.60%	58.9%	61.2%	70.6%	63.6%	65.7%	42.9%	37.50%
	Spend on Psychological Therapy Services (IAPT and non-IAPT): Rate (£000s) per 100,000 aged 16-64 (mapped from PCT)	2010/11	£1,021	-	-	£829	£1,396	£1,075	£1,749	£1,869	£251	£251

Domain	Indicator	Time Period	England			Gemma & Mary	Daniel	Isabelle	Melissa	Kevin	Chris	Rebecca
			Average	Lowest	Highest							
Common Mental Health Disorder Pathway	Secondary care contacts for Common Mental Health Disorders: Rate per 100,000 population aged 18+	2014/15 Q1	532	0	2,352	466	319	1,214	1,663	745	667	572

*value estimated

Most recent values used

Robust

Some concern

Significant concern

Compared with England Average Benchmark

Lower

Similar

Higher

Not tested

11.8 Transcript Key

I: Interviewee

R: Researcher

G: Gemma

M: Mary

In vivo quotes are edited for clarity. Other non-verbal communication is identified as follows:

- Emphasis of words is in **bold**
- Laughter is labelled as (laughs)
- When a participant sighs this is indicated as (sighs)
- Dots (…) indicate textual omissions or pauses

11.9 Example of All Master Themes/Subordinate Themes with Supporting Key Data

11.9.1 Practitioner Group: **"Daniel"**

Master/Sub-Ordinate Theme	In Vivo Quote	Line(s)
A Call to Action		
Bringing to Order to Disorder	whilst they're not NICE approved..at the moment, what we..we..what they do is, they're all IAPT compliant in terms of them recording measures and documenting..obtaining and monitoring the outcomes of what they do, so that its generating a body of evidence, at least locally about..that its you know..effective	392-395
Constructing Service Effectiveness	its interesting how patients perceptions about what they found helpful, or how well they're treated or how useful they find certain course doesn't necessarily map exactly onto clinical outcomes as measured by, your measures	417-419
Contextual Influences on Service Operation		
Embracing Constant Change	we haven't actually gone heading off in different directions, other than kind of refining that..and trying to operationally improve our systems to make it work as well as possible, for as many people as possible, in the context of the way that..that's kind of by local geography and service configurations outside of our services and so on..and referral patterns and issues	379-383
Significance of Agency	I think geography is a particularly prominent influential factor in [...], because of the geography, I know I've been going on about that..but I think its true. And we regularly get..you know issues that arise with people that say…"no sorry, I can't get to that clinic, on that day, or at that time", "its too far to travel", all these sort of things…	409-412
Inheriting the Old Service	its like somehow you're in some petri dish with a bunch of other IAPT services leads and..and…, clinicians and staff were grown that didn't know anything else…and thats just what they started doing	497-499
The Intermediator's Dilemma	I think it would be fair to say that in our service we do try and minimise the rest of the bureaucracy side of things, bureaucracy has been a huge play upon public services	466-468
Focus on Relationships		
Incoming Clients: Striking a Balance between Individual and Utilitarian Needs	Theres always the thorny issue of patient choice versus clinical evidence to whats most helpful..which is something that has to be kind of titrated with each individual case really	200-202
The Role of the GP	its managed self-referral in the sense that its supposed to follow a consultation with the GP, as opposed to just somebody picking up a leaflet lying around in the waiting room somewhere	19-21
Orchestrating a Cultural Shift and Protecting the Workforce	one thing we do not do is arrange for all initial assessments to be done the psychological wellbeing practitioners….We don't believe that..that's a sensible way to deal with intake assessment, we believe that um…initial assessment, um..is most safely and effectively and robustly carried out by people who are better trained…have more experience	37-40

11.9.2 Client Group: **“Felicity”**

Master/Sub-Ordinate Theme	In Vivo Quote	Line(s)
A Personal Journey: From Discovery to Advocacy		
Navigating the Unknown	my feel of GPs these days is…and this is probably very generalised and you’ll laugh at me..is the fact that they’re very happy to throw drugs at you rather than send you and assess	79-81
Surviving the First Stages	To chat about what’s something..something that is very personal to you is very hard	138-139
Feeling a Connection in Therapy	I thought she was particularly good, yeah particularly good. Yeah…yeah..she just had a really nice pace to the way she spoke as well, it was very controlled..she knew exactly what she was saying..	243-245
Sense of Duty and Responsibility	Its alright coming here, but you’ve actually got to and try some of this stuff, without actually making them feel like they’re being preached to, you’re being preached to, I don’t know	462-465
Perception of Self		
Finding the Right Fit	So going to counselling and suddenly someone going, right, tell me whats wrong with you, don’t know?! I’ve never even thought about it, I know I need to be here	148-150
How the Service Sees Me: Including Challenges to Identity and the Role of Language	Yeah, I must admit, on those..those..forms that we fill, and it says..patient’s name at the top I thought..well..I didn’t like patients name. I didn’t like patients name at all..made me feel like I was clinically ill, and I was in a straight jacket!	505-507
The Enabled Self: Validating Recovery	I think if you show people graphs and progress they will come again	358-259
Outside Factors		
The Role of Others	I’d had a friend who had had counselling who sort of [...], and said it was the best thing he ever did..	107-108
The Necessary Journey	Location is perfect me, I could literally walk there, its 5 minutes from me	65

11.10 Examples of One Master Theme/One Subordinate Theme with Supporting Key Data

11.10.1 Practitioner Group: **"Gemma** and **Mary"**

Focus on relationships	
Orchestrating a Cultural Shift and Protecting the Workforce	
In Vivo Quote	**Line(s)**
M: We actually have a pathway that's written.. a written pathway, which is not always adhered to.... and so then we need to have conversations but yes	20-22
G: obviously try and make sure that people are working within their competency, but the complexity of patients sometimes has always been a debate	136-137
G: And also we've had.. we've had what would you call them? Re-ogranisations and rationalisations, we've had counselling hours taken but, and we've had them put back in and then taken but, so it's been very up and down..	152-155
G: because we very much want to get it the same as.. that the wait for CBT and the wait for counselling is the same.. There's no you know, sort of discrepancy	173-174
M: it depends on the personality of the counselor... as to how well they are received in the practice	189-190
M: .even though it knows some services start out with that PWPs are put in like.. in like.. a call centre, we always said we wouldn't do that, but actually the telephone work they do is actually the most productive work.. G: they love it! M: .and they actually now that they're in to it they enjoy doing it. We started off doing a lot of persuasion and we had the headsets quite very early on and you know they were really hated... nobody would go near them, but once they used them, they felt, and realised they could type at the same time as they could speak, without neck ache, and any problem, it's just reduced the amount of admin time they need...	258-265
M: Slightly different from the counsellors because it's something that traditionally they feel interferes with the counselling session... so we've had to, we've had to sort of persuade them that.. that... well in actually fact we've got to do it because if we're going to be an IAPT service they were, they have to do it	277-281
G: our PWPs are supervised and managed by a PWP, and that changed quite early on. We did start off with supervision from a CBT therapist, but what we found is that they were being encouraged to work in a far more intense way, than their training had enabled them to do, so very quickly we tried and pushed and we've now got a very senior PWP, who does all the support of their trainees and supervises and caseload manages the PWPs staff, so they are very much kept within the discipline, of what they've been trained in, which is fab, that's worked really well	338-344
G: different people work differently, in reality, we don't have an necessarily quite strict protocol on that	357-358
G: also everyone is quite closely caseload managed so we see an overview, as a caseload manager I can see their graph, I can see what their scores are doing versus what the patients reporting, and if nothing is changing at session 6 I would be challenging whether should we really be proceeding	371-374
G: I think at first we thought oh no, we're not having people sitting just you know, on the phone, and I think that we don't, our PWPs don't just do that because actually we want to keep them, and we want them to make the job as interesting as possible	454-456
G: We had a lot of problems locally with the PWP training, where we felt that the PWP role would be learnt in their training and therefore we could then apply what they learned, we then learned very quickly that they didn't have a clue, training was appalling,	460-463
G: And there, then the training they had was absolutely the best of the best, so they went from one extreme to the other	466-468
G: the strength has been in our PWPs. In that they didn't say well we've been trained in this way and we're not going to do this work that we've now been trained to do, they really wanted to do what they had now been trained in.	475-478
M: we just kind of did our best, with a lot of trainees, a lot of inexperienced staff, and quite overwhelmed existing staff trying to hold everything together. So I think, well I found it quite an extremely stressful time with, at times quite anxious staff, who really were not sure, who, you know quite a lot of generalised anxiety within the team, and we responded to that	557-561
M: and we only had 1 administrator, well 9 PWPs and 9 high-intensity trainees so if you think about that, that's pretty overwhelming	564-565

11.10.2 Client Group: **“Michelle”**

Perception of Self	
How the Service Sees Me: Including Challenges to Identity and the Role of Language	
In Vivo Quote	**Line(s)**
she said I think you need to go and talk to somebody… and I really wasn’t keen to be honest, and I said shall we try a higher dose first?	13-14
that really didn’t bother me… because I really didn’t want to access the service anyway, because I thought oh.. oh.. no, not keen.	21-22
I said oh that would be perhaps suit me better really, I didn’t want to sit in a room with people that I didn’t know..	36-37
No I didn’t think I did want to be face to face.. I.. I think I did want to be, I wanted it to be anonymous really..	54-55
at the time I wasn’t really.. wasn’t.. in the best place to talk about it	70-71
everything was written down and then posted it back to me.. and said you said this, do you agree with the way its been documented? And that was good, because its sort of.. sort of a reminder of what we talked about… So it was quite transparent	103-106
know it was really good.. and I felt quite in control about the whole thing	134-135
Yes it was always face-to-face.. and when I was doing that yes I thought it was… it was easier to talk to someone, and I think because it was away from my home… as well… like a neutral sort of area really… Like.. if she would have come to my home I wouldn’t have liked it really you know….	177-179
No they were fine. I didn’t mind them and they didn’t intrude.	213-214
I know I can’t go and see her I’ve got these sheets which I’ve kept that I’ll be able to look through and go back to.. you know.. something to fall back on.	219-221
I just put the time aside.. I was just quite adamant and strict with myself.	232
they said 6 sessions so I thought thats what I’ve been allowed… but I thought yes, yes, I’m going to go for this and get everything I can out of it	260-261
because its self-referral. And I could always do that.. I might not get to see her, but I could always..	272-273
Well I didn’t want to go to be seen anyway did I?	279
I would say you’ve definitely got to take control and try out all the homeworks… you’ve definitely got to do that, because your therapist can only do so much really..	285-287
I didn’t really like that mantinging but thats part of it	344
Yes.. yes definitely. All along the way I felt in control.. like if I wanted to go or if there was one thing I wasn’t so sure about on the sheets she’d go through with me… yeah it was good. Its just at the.. at the end thats slightly worrying, but being engaged with.. its good.	375-377

11.11 Extract from Emergent Themes Analysis: Abbreviated Comments

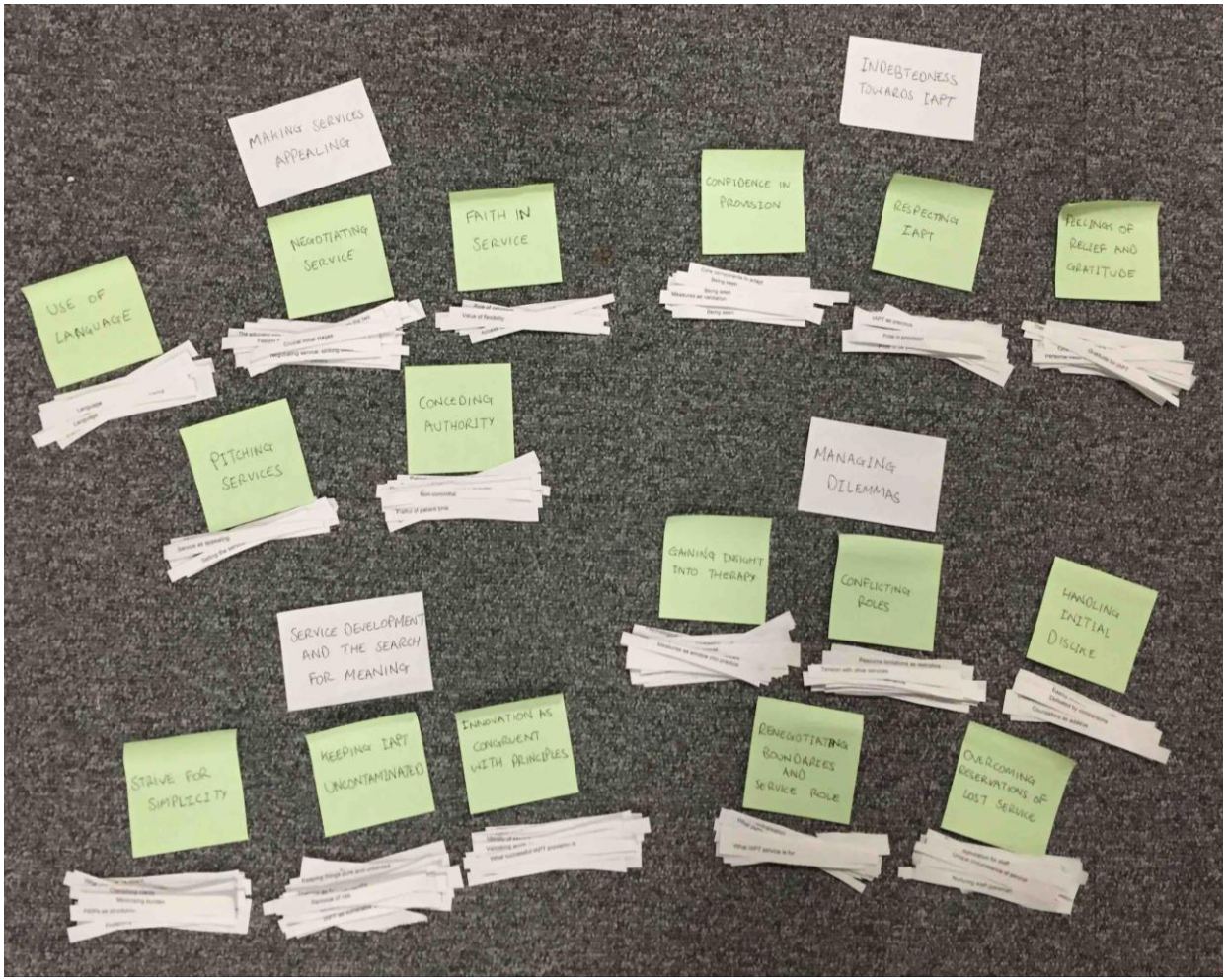
11.11.1 Practitioner Group: **"Melissa"**

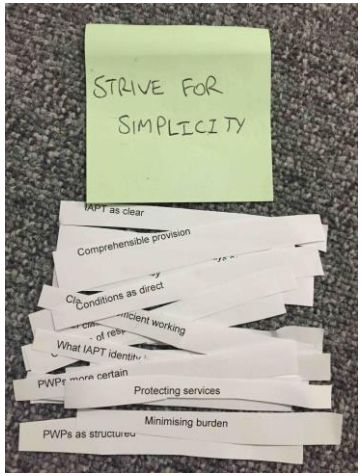
Key: Descriptive, *Linguistic*, **Conceptual**		
Emergent Themes	**Original Transcript (lines 414-434)**	**Exploratory Comments**
IAPT as misunderstood IAPT stripped and dehumanised IAPT identity Re-aligning definitions Pressure IAPT as part of wider picture Tension with critiques of IAPT Unique circumstance of service Idealistic expectations Concern for good work being lost Protective of IAPT Rejection of recovery model IAPT as integral Avoiding idealised claims Sympathetic role The educator role	I: IAPT is a population tool..and its about, its about trying to increase access to therapy, via a given population and I think very frequently, comparisons are drawn, or with, (sigh) the experience of individual therapy so um..you know whether CBT is a preferable approach to psychodynamic psychotherapy, and I think thats not the point, thats not what it is. Um..and, I think some of the claims and expectations of IAPT services around their inception..yes you know, don't bear up, if you want to encourage huge swaves of people you're not going to do it by,..you know through psychological interventions, if you can create huge swaves of people to get into work, then what you need to do is provide people, provide the jobs for example,...and if you're working with a population like [...] where, which has been very hard by austerity and there are very vulnerable groups of people, you are not going to create happiness if you like, if you take the current Layard type thesis through IAPT services, in fact what you can do however, is provide some tools, not all of the tools, for coping a bit better, and you can help some people be a little bit more comfortable, but you know, don't think of recovery, don't think of sorting it all but, its not going to do that...But for some people, it gives them some more coping resources, not the only resource, you know..and for a lot of our clients we need also to be sign-posting..them or directing them to housing advice, financial advice, linking them in to positive employment, finding all support agencies, you need to be connecting them to community groups that..reduce their social isolation, and so on, and so on. And so, you know..if you think that psychological interventions would ever, of any therapeutic persuasion actually okay do the trick, you know...they're not, particularly for a population, however, alongside a whole raft of other measures there may make people's live a bit..a bit more bearable.	Trying to rationalise and make sense of the IAPT programme **believes it is misunderstood and caught up in the wrong type of debate; is simplifying and stripping down the goals to the essentials of IAPT** *Population tool description* **reflects large volume working** Comparisons **not perceived to be fair** *Repetition and hesitation in speech* Re-align definitions and re-visit goals **emphasising the ultimate goals is useful for validation and reassurance** *Sigh* **weary of it being misunderstood and risk associated with this** **Taken on IAPT identity and attack on IAPT goals is like an attack on herself; may also be restricting the service and reading carefully potential lost** **What is IAPT? its purpose, argument is misaligned** Being diplomatic and recognises issues in its early days **early inception rushed and idealistic but not less valuable; concern that all the good work so far will be lost because its not meeting unfair targets** **Trying to rationalise and make sense of the IAPT programme believes it is misunderstood and caught up in the wrong type of debate; is simplifying and stripping down the goals to the essentials of IAPT** Social problems, outside factors; **Not seen to be the whole solution to all wrongs, but integrated in all areas to offer their contribution** *Huge swaves metaphor* **desperate by volume of people suffering** What is their purpose? **Providing tools; avoiding the idealised claims and criticisms and recognising the actual contribution; need to step back and realise you are good enough** Apprehension for thinking in a way that is not helpful **not an illness to be cured, resentful and irritated by people devaluing their important work** Being more realistic *Repetition;* **holistic working, drawing on multiple resources, devotion and care for service-users (but target driven work is to treat and reduce the symptoms measuring this is difficult)** *Genuine warmth and concern in her voice* **Valuing her clients; sympathy and affection for them, optimistic and pride in their value as part of a wider movement**

11.11.2 Client Group: **"Michelle"**

Key: Descriptive, *Linguistic*, **Conceptual**		
Emergent Themes	**Original Transcript (lines 41-70)**	**Exploratory Comments**
Gaining a voice Finding the right fit Social relationships motivating Seeking validation Service as encourager Being congruent Gained independence Change as fulfilment Self as performance Enhanced self Teaching relevance to life Application of skills Contrast in selves Small victories Work of managing self The liberated self Snowball effects Confirmation of worth	I: Um…. there was a certain amount of information given, but it was mainly a sense of relief that somebody was going to listen to me, **yeah** I would say that. I really can't remember what was said but I know it was correct.. because they were guiding me through the process all the time, but I can't tell you verbatim what was said, but I felt very comfortable with the service, what was being offered at the time it was being offered, because they built on it. Day-by, .. or week-by-week, once I was having the appointments, ..week-by-week there were opening doors for me, and I felt, I do feel now a year on, enabled because of what they've taught me so, I do know that they're taking the right steps. Even today.. because as I explained to you earlier I walked down from home because, and we sorted out the route beforehand.. because I've not walked this route before, and leaving enough to know I was going to get here, and if I got lost I'd be able to contact someone.. and.. and.. ask… Before I would have been very panicked and very anxious and worried, and it actually went beautifully and I was 20 minutes early. And thats the kind of thing…just practical things like that, just takes the stress and pressure off you.., not building it up in your head, and looking at what will go wrong all the time. So theres more to it than that, but thats just as an example, those little victories, makes you feel good, because you know that you can do more.	Feeling justified that she is in the right place; *relief sensed in her voice* **possibly reliving the feeling she had, showing how powerful it was** Clarifying in her own head, memory hazy but that feeling sticks through Level of clarity, making sense for her **Were experiences up until that point characterised by great uncertainty and isolation?** Thankful for gradual build up *process in the language, slowly building* **done as to not feel overwhelmed, possible enhanced sensitivity in this stage** Elsewhere in transcript she is seeking the recognition of other **is validation of other important for engagement?** *Metaphorical of opening doors* **new sense of freedom, able to go anywhere and see the change in her own life** Still feeling the impact **feeling as though she has to prove herself to others – is she feeling a responsibility towards the service?** Conscious of a way out Contrast in self before and after service **feeling more enabled, remembering her old self and seemingly quite shameful of it?** Mood characterised by stress *pace of speech suggesting incredibly arduous experience and not keen to remember it* Downplaying certain things as small **the small changes have the biggest impact?** Feeling the weight usually is too much **service engagement taken to mean this weight has been lifted? Did the therapist do this? Or did Michelle?** Expecting things to always go wrong **recovery about being prepared?** Revealing her potential, gradual change and revelation; **testing in the world is just as important**
	R: Yeah, and what was the first session like in terms of accessing it, with your anxiety considered on new meetings? Did you have to plan what you were going to say and how you got there?	
Sensitivity in initial stages Reliving trauma Earning your right to be in therapy Gaining a voice Sense of isolation Role of the service Prolonging difficulties	I: No.. No.., it all just came out really, gushed everything out. The first meeting was really … what I would call an initial interview to establish where I was at and, I just let it all go, and really told her everything about how I felt.. about my marriage, my husband, relocating…, and feeling quite lost in the area. Because I'm not from round here, and you come here and its different.. I'm sorry but the whole work life ethos, and the approach to people, but its what everybody's used to.. because.. everybody's done it.. but when you come, and you're obviously.. because I found out much later.. very unwell.. can't	*Repetition of no and use of the word gushing* initial stages overwhelming, **overwhelming emotions due to being in denial for so long?** Considered to be an interview **being worthy of the service? As though she was ill enough to be considered worthy of treatment** Decision to engage not her own but influenced by others, such as her husband Feeling isolated and without control due to new area **Service access as a means to gain some footing in the world and take some time to reflect; role of the service to take a break from daily life?** *Apologising for the different areas* **Own personal guilt for fitting in** *Staggered speech, difficult to manage and cope with in the situation*

11.12 Individual Participant Superordinate Theme Development Example





11.13 Extracts from List of Emergent and Superordinate Themes from all Participants

11.13.1 Practitioner Group

Daniel			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Focus on agency	Patient mobility an issue	251	geographically challenging area
	GP alliance	122	working closely with the GPs
	Balancing ideal with reality	228	there's only so much wasted time we can put up with
	Delivering flexibility	181	theres no strict projects
The authenticated service	Integrating service values	493-494	we've all had to adjust and absorb and integrate the IAPT methodology
	The identity of IAPT	127-128	an IAPT service which does what it says on the tin
	Pulling together	37	all staff take a role in it
	Validating worth	395	so that its generating a body of evidence, at least locally
	Endorsing IAPT	453	IAPT is without question, been a good thing
First Impressions	Sensitivity in initial stages	200-201	thorny issue of patient choice versus clinical evidence
	The right patient	32	establish whether indeed this could be a helpful service
	From paternal to autonomous	155	at least to start with
Actualising service potential	Staff determination	368	sometimes it depends on individual clinicians' interest
	Impact of old service on operations	258	Not by the current managers but, previous ones
	Perfecting services	273	refine and improve and consolidate the most helpful
	Multiple obligations	381	work as well as possible, for as many people as possible

Melissa			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Vulnerabilities of self, service and IAPT	Admiration for IAPT	439	so much attention to detail has been given
	The strained service	376	there always tension points for us
	Managing unrealistic expectations	418	the claims and expectations of IAPT services around their inception, yes you know, don't bear up
	Sharing boundaries, definitions and understanding	24-25	our GPs were not particularly clear about the referral criteria
Vital role of assessment	Sensitivity in initial stages	126-127	if we can reduce that, if we focus on delivering the therapy
	Losing boundaries of assessment	110-111	the initial assessment is meant to be of a screening nature however
	Influence on therapy	107	how much energy the expend on assessment versus therapy
The transformative service	Broadening roles and service	342-343	I'd like us to be seeing people with, ... a personality disorder
	Showing humillity	318-319	I think we're doing a lot, but we can do more
	The integrative role	433	alongside a whole raft of other measures
	Enduring service metamorphisis	317	yes of course there has been service developments
Pressure of unique circumstances	Being sensitive to context	272	We tend to see people at the more severe complex end
	Stress of accommodation	247	bursting out of the seams as it happens
	Envy of other services	246	in XX for example you find its a better placed
	Assimilating service	399	integrated and connected with a whole range of other services
	Inheriting old service tensions	359-360	actually trying to work with waiting, tremendous waiting lists

Isabelle			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
The authenticated self	False perceptions of outcome measures	385	doesn't get measured as recovery through the KPIs
	Desire to be seen	601	you can send more, please send us more
	Being congruent with IAPT identity	324-325	it means that you know, people stick to the protocol
	Being just and fair	334	we get that standard, kind of, clinical intervention across
	Validating worth	400	I know that we have got some really good success stories
The role of relationships and place in care	Being unnoticed, misunderstood or overlooked	610-611	this thought that we have massive waiting lists, but we don't
	Bridging gaps	57	trying to bridge that gap
	Negotiating service	107-108	tests their, you know, kind of commitment and motivation
	Sensiitivity in initial stages	605-606	if you refer them earlier, we can actually deal with the problem
	Overcoming follow-up issues	345	in the process of making a relapse prevention area on our website
Indebtedness towards IAPT	Making admissions for service	462-463	IAPT was you know a pretty new initiative really wasn't it?
	Changing role of IAPT	509	the goal posts have moved
	Gratefulness and pride in IAPT movement	506	I think what IAPT services are doing are very effective
Integrating service	Uniqueness of service	326-327	we think that's because of the models that we've adapted
	Service as open	373	I don't think we turn anyone away to be honest
	The enhanced service	470-471	the introduction of technology, you know we're looking at e-clinics now
	Developing shared language	531-532	If people actually think, yeah this is something I can really engage with

Kevin			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Making services appealing	Use of language	162	its all about how you explain
	Negotiating service	297-298	its part of your preparation for the treatment session
	Faith in patients	260	the focus is on them
	Conceding authority	227-228	if you were going to do one of these things, what do you think you might do
	Pitching services	205	the good news is that the treatment that we have for these is very effective
Indebtedness towards IAPT	Feelings of relief and gratitude	6	Well any excuse to talk about IAPT
	Confidence in provision	449-450	we'll do well on that
	Respecting IAPT	539	well the whole thing is beneficial isn't it
Service development and the search for meaning	Innovation as congruent with principles	106-107	we brought self-referral in straight away, because we knew the evidence base
	Keeping IAPT uncontaminated	21	we keep the IAPT pure
	Strive for simplicity	45-46	sounds like its a fairly straightforward IAPT problem
Managing dilemmas	Overcoming reservations of lost service	248-249	they put the emphasis on the relationship with the practitioner
	Gaining insight into therapy	267	we learned from supervision
	Conflicting roles	604	My own personal gripe is
	Handling initial dislike	561	we were a bit unpopular in the early days
	Renegotiating boundaries and service role	513-516	you've robbed Peter to pay Paul

Rebecca			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Influence of IAPT	IAPT as inevitable dominant force	621	its all going the way of IAPT
	Envy of IAPT	392-393	the benefit is the way that IAPT services are structured
	Coping with IAPT high volume philosophy	242	you cannot, you can't have the luxury of going round
	Service refinement as making sense with IAPT	280	There seems little value in really, you know sending people on other courses
Managing dilemmas	Tension between the many and the individual	248-249	what you've done is wasted 4 appointments that they didn't attend
	Managing gaps	357-358	having those kind of bullfights of well its yours
	Action justification in context	253	if they can do it in cancer care, I think we can do it in mild-moderate mental health
	Transforming culture	238	it has been a little bit difficult, I suppose culturally for the team
	Re-establishing boundaries	232	we have made some adjustments to service boundaries around attendance
	Coping with old service	534-535	there were lots of issues around, leadership and what have you
Identity and the search for meaning	Unclear provision	106-107	we don't really have a criteria, so you know what do you say yes to, what do you say no to
	Feelings of isolation	596	we just had people cobbled together and just told to get on with it
	Balancing ideal with reality	203	where we're at in principle, but thats not necessarily where we're at in practice
	Overcoming limitations of service	287-288	we tend to do as well is make use of the resources around us

Chris			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Not belonging	Conflicted roles and responsibilities	609	its quite difficult to play that game, I find that difficult
	Feelings of confusion	596	so what am I?
	Making sense of conflicting ideologies	530-531	it flies in the face of BACP and BABCP requirements
Agency	Role of GPs	649-650	The key to a psychotherapy starts and ends with the GP
	Delivering flexibility	568	two of my team who work very flexible hours
	Being sensitive to context	83-84	was actually unmanageable for us
	Stress with accomodation	478-479	we don't have a footprint in this building
	Geographically challenged	107-108	in two unconnected geographical locations in the country, so its unusual
Service development and the search for meaning	Re-establishing boundaries	541-542	unfortunately what happens then is you can become a victim of your own success
	Authenticating service	390-391	from nobody with any qualifications, apart from me if you like, now everybody has
	Integrating service principles	476	its something that again, we've never done
The influence of IAPT	IAPT as stimulating change	221	because we're not totally working towards an IAPT model, we haven't felt the need to change
	IAPT as focused and transparent	502	its easy to see, its metricated, I get that
	Inevitable shift to IAPT provision	512	whats changed actually is the need for us to become IAPT compliant
	Emulating IAPT	539-540	the whole name of improving access to psychological therapy, kind of fitted what we did

Gemma & Mary			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Nurturing a transformative culture shift	Surprising practice	454-455	initially we thought it wasn't for us, but actually
	Multiple and changing pressures	596	until they change it again!
	Engaging staff	263	we started off doing a lot of persuasion
	In-service resistance	21	not always adhered to
	Integrating the old with the new	461-462	its our adaptation of the model
Managing unrealistic expectations	Initial rush of service implementation and incomplete service	560-561	overwhelmed existing staff trying to hold everything together
	Setting boundaries and recognition limitations	475	much more boundaried, much more clearer
	Balance between ideal and the practical	127	we, within reason, we do try
	False perceptions and hidden patients	606	make considerations for
PWPs as operative	Flexible application of PWPs	252	we offer a far more flexible service
	Keeping PWPs pure	345	they are very much kept within the discipline
	Cherishing PWPs	458	we want them to make the job as interesting as possible
	PWPs as basis for service effectiveness	478	the strength has been in our PWPs
Dynamic power relationships	The positive and negatives of using outcome measures	291	actually gives us something to focus on sometimes
	Developing shared language	207	might not fully understand
	Reducing barriers	48	we try and cut down
	In-service modality variance	181	from the counselling point of view its been, it was a historic thing

11.13.2 Client Group

Rachel			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
The consequences of engaging with other services	Constraint of other services	320	its not really affordable
	Coping with loss of CAMHS	236	been in between services, kind of on my own really
	Comparing and making admissions for service	275	maybe that prior experience influenced my expectations
	Seeking novelty and uniqueness	236	I'll go to new things like this
The reserved self	Reluctance to voice concerns	281	I don't like just saying things
	Longing for personal contact	47-48	I did kind of prefer talking face-to-face
	Impact of social norms and pressures	224	didn't want to tell them I suppose
	Feelings of puzzlement	155	then again I don't know if thats just me reading it
	Sensitivity in initial stages	41	you're there telling a complete stranger
Service engagement as arena for learning and self-reflexivity	Gained self-awareness and clarity	213-214	I didn't know about myself before
	The learned self	288	the learning was good
	Vulnerabilities of memory	360	my memory is really bad
	Self as performance	376	if it can crack it, that will sort me out for life
	Developing new skill set	344	it gave you the tools to try and fix it
	Confused use of scores	176	I didn't get the bit where they didn't seem to evaluate that
Function of service	Self in context	242	I was having a good day because I was going to see her
	Therapy as substitute to medicine	12	trying to find that alternative way of doing it
	Duty towards service	95-96	a lot of people who would want that opportunity
	The role of language	198	they were quite clear in explaining it

Michelle			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Focus on prior and external factors	Detrimental influence of relationships	188	coping with my mother
	Dissatisfaction with health services	286-287	something is not right somewhere, because something is getting missed
	Prior engagement with services	338	previous counselling I've had is
	Gratitude and sense of duty	467-468	not trying would not be the right thing to do
	Concern for GPs	295	seems to me that GPs are so rushed that they're not really joining the dots
	Confronting preconceptions of service	104-105	it was a real relief to find out it was on the doorstep
The authenticated self	Scores as validation	374	an acknowledgement, that it wasn't just me thinking
	Self as performance	392	you need to be motivated
	Seeking recognition from others and service	224	I think she was pleased that I'd recognised that
	Being seen	167-168	she seemed to understand where I was coming from
Focus on therapeutic relationship	Apprehensive of over the phone therapy	151	telephone can be a bit impersonal
	Captivated by therapist	208	this particular counsellor, I felt encouraged from day one
	Feeling valued and heard	41-42	mainly a sense of relief that somebody was going to listen to me
	Seeking human contact	154	for me, one-to-one, personal contact is better
Service engagement as congruent with self	Developing shared language	220	I know what she's telling me
	Finding the right fit	126-127	the right decision for me
	Service as safety net	414	I knew the back-up was there
	Sense of belonging	404	I just felt totally in the right place for all this
	Gaining control over agenda	213	once you start you can see where you're going with it
	Self in context	453-454	I think it's very dependant on who you are speaking to at the time and where they're at

Sarah			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Coping with service anxiety	Reluctance to engage and confront self	21	I didn't want to go
	Sensitivity in initial stages	370	I was actually dreading it
	Overcoming service preconceptions	283	it wasn't like I thought it was
	Fear of being seen	54-55	I wanted it to be anonymous really
Longing for safety in the service	Materials as safety net	219	I've kept them in a folder so if I do slip
	Finding stability in chaotic lifestyle	26-27	my life was just spiralling
	Awareness of service as reassurance	273	I could go back to the service and back myself
	Service as safe space	179	like a neutral sort of area
Affinity for service	Duty towards service	441	you need to get out there and test it yourself
	Gained insight	453	I realised then that
	Indebtedness towards therapist	195	she has honestly given my life back to me
	Endorsing therapist	266	She was very good, very positive
The will to act	Being withdrawn	78-79	never told anybody
	Intrinsic motivation	28	this isn't the way to carry on
	Living with unwanted self	84	I blame myself entirely
	Loss of life	187	I wasn't really talking to anybody
	Contrast in selves	421	I'm not as bad as I was
The authenticated self	Seeking recognition from others	247-248	my husband had noticed as well
	Normalising experience	401	nice to see other people with similar problems
	Scores as validation and additive therapeutic element	206	show that you have improved
	Longing for follow-up	316-317	I think a follow-up would be beneficial in the long run

Kate			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Service as transforming self	Becoming service champion	261	I've recommended it
	The liberated self	360	its given me, my boost of confidence
	Gained insight/revelation	122	the information has really sunk in and helped me
Focus on external factors	Dependency on others	201	I do rely on my dad a lot
	Social relationships influence	81-82	wanting to take my son to the park
	Reaching desperation	169	I was letting things get on top of me
	Accessible service	176-177	location was really good
Self as validation	Materials as validation	198	I felt a 1000 times better for doing that, to see it
	Seeking recognition from others	114-115	they would know what I was going through
	Search for meaning	182	would have been nice is if they'd done a review
Affinity for services	Idealising service	292	I can't think of anything wrong with it
	Indebtedness towards service	256-257	its made me the person I am today
	Service as time out from life	279	its my treat
	Longing for the service	16	I miss going
Engagement as intelligible	Language Use	220	they were all very clear and the way they spoke and everything
	Simplifying the complex	51	it was easy
	Feelings of congruence and belonging	354	it was perfect, the way everything was
	Vulnerable to forgetting	228	it was just mainly just to help me remember bits

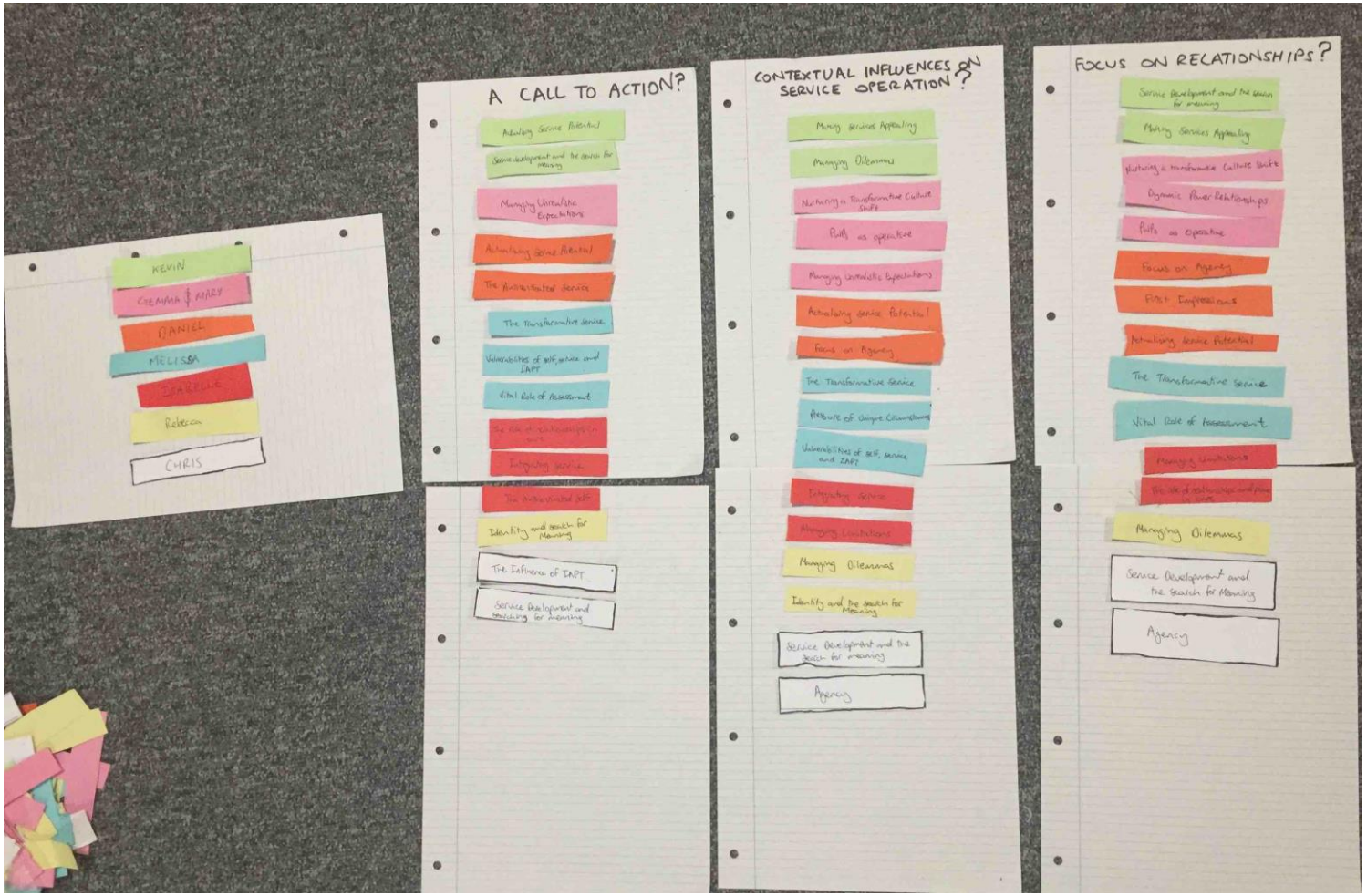
Maria			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Managing service anxiety	Sensitivity in initial stages	55	at the beginning, she didn't like it
	Poor awareness of services	246	Awareness is quite low
	Scores and change as validation	121	could see the difference every week
	Being grateful for access	92	close distance make it easier
Focus on therapeutic relationship	Attachment and kinship to therapist	137	she's nice, very good relationship
	Feeling valued and heard	256	I got all the support I have
	Therapist as motivator and encourager	65	they said she will get better that she was happy to go with it
	Seeking human contact	115	face to face help me…. I felt more comfort
The influence of external social relationships and self-perception	Perceived burden on GPs	247-248	can use that service rather than keep going to their GPs
	Dependency on others	236	she wanted someone to be there
	Seeking recognition of others	311	they started saying, 'you look better
	Personal responsibility	304	need to look after them
	Desire to come off medicine	276-277	couldn't go on relying on the medicine
Self beyond therapy	Service as safety net	147	really important to have this service
	Advocacy role	228	I'll want them to use the services so they can get better as well
	Coping as recovery	170	its not fully gone
	Contrast of selves	159	I felt myself getting better

Trevor			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
The psychological consequences of prior experiences	Prolonged condition	64	I've kind of looked at this many times over the last 30 odd years or so
	Being cynical	197	I would say without trying to be cynical, it's shut several times
	Extrinsic motivation	70-71	I was actually thinking this is the time that I pushed this on
	Low expectations	99-100	I wasn't expecting to get a great deal
Search for meaning	Unclear identity	120	am I high risk?
	Feelings of restlessness	80-81	I've had a mish mash of experiences
	Managing uncertainty	78-79	I didn't know where I was looking or what I was looking for really
	Feeling forced and restricted	206	you're made to fit the model maybe
	Impact of language	250	what's too much?
Coping with undesirable feelings in transitional care	Reluctance to open up on the phone	135	I'm not comfortable with that on a telephone
	Intrinsic determination	82-83	you've got to be bloody determined and focused
	Feeling isolated	152	nobody was there
	Overcoming social norms	243	we live in a society where we're not encouraged to potentially be honest
	Frustrated progress	176	puts you back to where you started with your GP

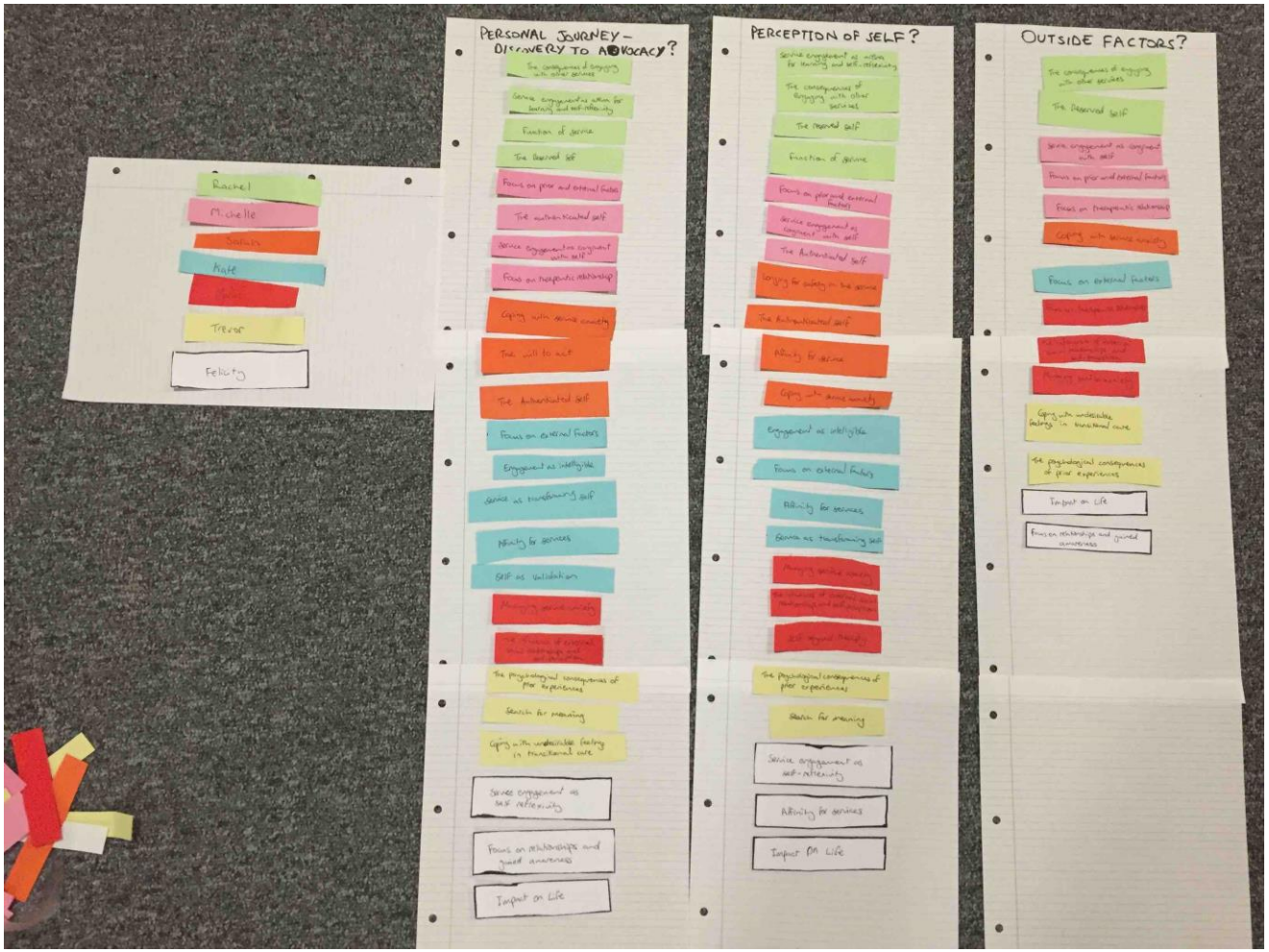
Felicity			
Super-Ordinate Themes	**Sub-themes**	**Line(s)**	**Key words**
Service engagement as self-reflexivity	Search for meaning	206	I really didn't know what was wrong with me
	Finding the right fit	444	if you think its silly or you don't think its right for you, give it a go
	Conflicted identity	512	I thought am I a patient?
	Longing for reflexive space	551	I'm feeding back through you ya see
	Desire for speeded engagement	492	engage people more immediately
Focus on relationships and gained awareness	Motivation for therapy	110-111	we're all each others' friends, so the kind of prompted
	External input	53-54	I'd read about CBT, and I'd heard a lot of things about mindfulness
	Captivated by therapist	242	she was brilliant
Impact on life	Accommodating therapy into life	278	its hard to commit to it
	Struggle to be referred	99	I was determined to be referred
	Impact of scores	314	the form didn't reflect that
	Making tools relevant to life	463	you need to use the tools yourself
	Recovery as coping	352	give people the tools to actually manage it
Affinity for services	Sense of duty	38-439	you've got to be prepared to have a go at certain things, but do the work yourself
	Intrinsic motivation	55	I was looking forward to it
	Advocacy role	138	highly recommend them
	Making admissions for service	27-28	I didn't think that was too bad really

11.14 Master Theme Development

11.14.1 Practitioner Group



11.14.2 Client Group



11.15 Superordinate and Subordinate Themes Leading to Master Themes across all Participants

11.15.1 Practitioner Group

Key:		
Name		Colour
Kevin	=	Green
Gemma & Mary	=	Purple
Daniel	=	Orange
Melissa	=	Blue
Isabelle	=	Red
Rebecca	=	Black
Chris	=	Grey

A Call to Action

Bringing Order to Disorder

- Super-ordinate themes

  Service development and the search for meaning
  Actualising service potential
  Managing unrealistic expectations
  Vulnerabilities of self, service and IAPT
  Vital role of assessment
  The role of relationships and place in care
  Integrating service
  Identity and search for meaning
  The influence of IAPT
  Service development and searching for meaning

- Sub-ordinate themes

  Innovation as congruent with principles
  Keeping IAPT uncontaminated
  Confidence in provision
  Strive for simplicity
  Renegotiating boundaries and service role
  Setting boundaries and recognition limitations
  False perceptions and hidden patients
  Integrating the old with the new
  Keeping PWPs pure
  Integrating service values
  The identity of IAPT
  Integrating service values
  Pulling together
  The right patient
  Impact of old service on operations
  Perfecting services
  The strained service
  The integrative role
  Managing unrealistic expectations
  Sharing boundaries, definitions and understanding
  Sensitivity in initial stages
  Losing boundaries of assessment
  Influence on therapy
  Broadening roles and service
  Being congruent with IAPT identity
  Sensitivity in initial stages
  Overcoming follow-up issues
  The enhanced service
  Being unnoticed, misunderstood or overlooked
  Changing role of IAPT
  Envy of IAPT
  Re-establishing boundaries
  Service refinement as making sense with IAPT
  Unclear provision
  Feelings of confusion
  Re-establishing boundaries
  IAPT as stimulating change
  IAPT as focused and transparent

Constructing Service Effectiveness

- Super-ordinate themes

  Service development and the search for meaning
  Actualising service potential
  The authenticated service
  Actualising service potential
  The transformative service
  The authenticated self
  Identity and the search for meaning
  The influence of IAPT

- Sub-ordinate themes

  Conceding authority
  Innovation as congruent with principles
  Gaining insight into therapy
  Renegotiating boundaries and service role

In-service resistance
False perceptions and hidden patients
PWPs as basis for service effectiveness
The positive and negatives of using outcome measures
Reducing barriers
GP alliance
Integrating service values
Validating worth
The right patient
Staff determination
Perfecting services
Sharing boundaries, definitions and understanding
Broadening roles and service
Showing humility
The integrative role
Being sensitive to context
Assimilating service
False perceptions of outcome measures
Desire to be seen
Being unnoticed, misunderstood or overlooked
Being congruent with IAPT identity
Validating worth
Uniqueness of service
The enhanced service
Service refinement as making sense with IAPT
Action justification in context
Overcoming limitations of service
Authenticating service
Integrating service principles
Emulating IAPT

Contextual Influences on Service Operation

Embracing Constant Change

- Super-ordinate themes
  Nurturing a transformative culture shift
  Actualising service potential
  The transformative service
  Integrating service

- Sub-ordinate themes
  Negotiating service
  Pitching services
  Confidence in provision
  Innovation as congruent with principles
  Overcoming reservations of lost service
  Handling initial dislike
  Renegotiating boundaries and service role
  Surprising practice
  Multiple and changing pressures
  In-service resistance
  Integrating the old with the new
  Initial rush of service implementation and incomplete service
  Balance between ideal and the practical
  Flexible application of PWPs
  Reducing barriers
  In-service modality variance
  Patient mobility an issue
  Balancing ideal with reality
  Delivering flexibility
  Integrating service values
  Staff determination
  Impact of old service on operations
  Perfecting services
  Multiple obligations
  The strained service
  Managing unrealistic expectations
  Sharing boundaries, definitions and understanding
  Broadening roles and service
  The integrative role
  Enduring service metamorphosis

Being sensitive to context
Stress of accommodation
Assimilating service
Inheriting old service tensions
Being just and fair
Bridging gaps
Overcoming follow-up issues
Changing role of IAPT
Service as open
The enhanced service
Coping with IAPT high volume philosophy
Service refinement as making sense with IAPT
Managing gaps
Action justification in context
Transforming culture
Re-establishing boundaries
Overcoming limitations of service
Role of GPs
Delivering flexibility
Being sensitive to context
Stress with accommodation
Geographically challenged
Integrating service principles
IAPT as stimulating change
Emulating IAPT

Significance of Agency

- Super-ordinate themes
  Making services appealing
  PWPs as operative
  Focus on agency
  Pressure of unique circumstances
  Agency

- Sub-ordinate themes
  Negotiating service
  Pitching services
  Strive for simplicity
  Balance between ideal and the practical
  Flexible application of PWPs
  Developing shared language
  Reducing barriers
  Patient mobility an issue
  Balancing ideal with reality
  Delivering flexibility

Sensitivity in initial stages
From paternal to autonomous
The strained service
Sensitivity in initial stages
Broadening roles and service
Being sensitive to context
Stress of accommodation
Envy of other services
Assimilating service
Being just and fair
Bridging gaps
Sensitivity in initial stages
Overcoming follow-up issues
Service as open
Coping with IAPT high volume philosophy
Tension between the many and the individual
Managing gaps
Balancing ideal with reality
Overcoming limitations of service
Role of GPs
Delivering flexibility
Being sensitive to context
Stress with accommodation
Geographically challenged

Inheriting the Old Service

- Super-ordinate themes
  Managing dilemmas
  Managing unrealistic expectations
  Nurturing a transformative culture shift
  Actualising service potential
  Pressure of unique circumstances
  Integrating service
  Service development and the search for meaning

- Sub-ordinate themes
  Pitching services
  Feelings of relief and gratitude
  Innovation as congruent with principles
  Keeping IAPT uncontaminated
  Overcoming reservations of lost service
  Handling initial dislike
  Surprising practice

Multiple and changing pressures
In-service resistance
Integrating the old with the new
Initial rush of service implementation and incomplete service
In-service modality variance
Integrating service values
Endorsing IAPT
Staff determination
Impact of old service on operations
Broadening roles and service
The integrative role
Enduring service metamorphosis
Assimilating service
Inheriting old service tensions
Negotiating service
Making admissions for service
Gratefulness and pride in IAPT movement
Action justification in context
Transforming culture
Re-establishing boundaries
Coping with old service
Being sensitive to context
Re-establishing boundaries
Integrating service principles
IAPT as stimulating change

The Intermediator's Dilemma

· Super-ordinate themes
Managing dilemmas
PWPs as operative
Actualising service potential
Vulnerabilities of self, service and IAPT
Pressure of unique circumstances
Managing limitations
Integrating service
Managing dilemmas
Identity and the search for meaning

· Sub-ordinate themes
Negotiating service
Strive for simplicity
Overcoming reservations of lost service
Renegotiating boundaries and service role
Multiple and changing pressures
Engaging staff
Setting boundaries and recognition limitations
Balance between ideal and the practical
Flexible application of PWPs
Reducing barriers
In-service modality variance
Balancing ideal with reality
Delivering flexibility
Pulling together
The right patient
Staff determination
Perfecting services
The strained service
Managing unrealistic expectations
Sharing boundaries, definitions and understanding
Losing boundaries of assessment
Influence on therapy
Stress of accommodation
Envy of other services
Assimilating service
False perceptions of outcome measures
Negotiating service
Overcoming follow-up issues
The enhanced service
Coping with IAPT high volume philosophy
Service refinement as making sense with IAPT
Tension between the many and the individual
Action justification in context
Balancing ideal with reality
Overcoming limitations of service
Delivering flexibility
Being sensitive to context
Stress with accommodation
Geographically challenged

Focus on Relationships

Incoming Clients: Striking a Balance between Individual and Utilitarian Needs

- Super-ordinate themes
  - Making services appealing
  - Dynamic power relationships
  - Focus on agency
  - First Impressions
  - Vital role of assessment
  - Managing limitations
  - The role of relationships and place in care
  - Managing dilemmas
  - Agency

- Sub-ordinate themes
  - Use of language
  - Negotiating service
  - Faith in patients
  - Conceding authority
  - Pitching services
  - Keeping IAPT uncontaminated
  - Strive for simplicity
  - Renegotiating boundaries and service role
  - Setting boundaries and recognition limitations
  - Balance between ideal and the practical
  - False perceptions and hidden patients
  - Flexible application of PWPs
  - Keeping PWPs pure
  - PWPs as basis for service effectiveness
  - Developing shared language
  - Reducing barriers
  - Patient mobility an issue
  - Balancing ideal with reality
  - Delivering flexibility
  - Sensitivity in initial stages
  - The right patient
  - From paternal to autonomous
  - Sensitivity in initial stages
  - Losing boundaries of assessment
  - Influence on therapy
  - Broadening roles and service
  - Showing humility
  - The integrative role
  - Stress of accommodation
  - Desire to be seen
  - Being just and fair
  - Bridging gaps
  - Negotiating service
  - Sensitivity in initial stages
  - Service as open
  - The enhanced service
  - Developing shared language
  - Coping with IAPT high volume philosophy
  - Managing gaps
  - Tension between the many and the individual
  - Managing gaps
  - Re-establishing boundaries
  - Unclear provision
  - Balancing ideal with reality
  - Role of GPs
  - Delivering flexibility
  - Being sensitive to context
  - Stress with accommodation
  - Re-establishing boundaries

The Role of the GP

- Super-ordinate themes
  - Service development and the search for meaning
  - The role of relationships and place in care
  - Agency

- Sub-ordinate themes
  - Keeping IAPT uncontaminated
  - Strive for simplicity
  - Overcoming reservations of lost service
  - Renegotiating boundaries and service role
  - Multiple and changing pressures
  - Initial rush of service implementation and incomplete service
  - Setting boundaries and recognition limitations

Reducing barriers
GP alliance
The right patient
Multiple obligations
Sharing boundaries, definitions and understanding
The integrative role
Desire to be seen
Uniqueness of service
Service as open
The enhanced service
Service refinement as making sense with IAPT
Re-establishing boundaries
Role of GPs
Geographically challenged
Re-establishing boundaries
IAPT as stimulating change
Impact of old service on operations
Perfecting services
Losing boundaries of assessment
Influence on therapy
Broadening roles and service
The integrative role
Being congruent with IAPT identity
Uniqueness of service
Service as open
Service refinement as making sense with IAPT
Transforming culture
Coping with old service
IAPT as stimulating change
Inevitable shift to IAPT provision
Emulating IAPT

Orchestrating a Cultural Shift and Protecting the Workforce

- Super-ordinate themes
  Nurturing a transformative culture shift
  PWPs as operative
  Actualising service potential
  The transformative service
  Managing dilemmas
  Service development and the search for meaning

- Sub-ordinate themes
  Innovation as congruent with principles
  Gaining insight into therapy
  Renegotiating boundaries and service role
  Surprising practice
  Engaging staff
  In-service resistance
  Flexible application of PWPs
  Keeping PWPs pure
  Cherishing PWPs
  PWPs as basis for service effectiveness
  In-service modality variance
  Pulling together
  Staff determination

11.15.2 Client Group

Surviving the First Stages

- Super-ordinate themes
  - The consequences of engaging with other services
  - The reserved self
  - Focus on prior and external factors
  - Service engagement as congruent with self
  - Coping with service anxiety
  - The will to act
  - Focus on external factors
  - Engagement as intelligible
  - Managing service anxiety
  - The influence of external social relationships and self-perception
  - The psychological consequences of prior experiences
  - Search for meaning
  - Coping with undesirable feelings in transitional care
  - Service engagement as self-reflexivity
  - Impact on life

- Sub-ordinate themes
  - Coping with loss of CAMHS
  - Comparing and making admissions for service
  - Seeking novelty and uniqueness
  - Reluctance to voice concerns
  - Longing for personal contact
  - Impact of social norms and pressures
  - Sensitivity in initial stages
  - Confused use of scores
  - Self in context
  - Therapy as substitute to medicine
  - The role of language
  - Dissatisfaction with health services
  - Prior engagement with services
  - Gratitude and sense of duty
  - Detrimental influence of relationships
  - Concern for GPs
  - Confronting preconceptions of service
  - Apprehensive of over the phone therapy
  - Captivated by therapist
  - Seeking human contact
  - Developing shared language
  - Gaining control over agenda
  - Self in context
  - Reluctance to engage and confront self
  - Sensitivity in initial stages
  - Overcoming service preconceptions
  - Fear of being seen
  - Finding stability in chaotic lifestyle
  - Being withdrawn
  - Intrinsic motivation
  - Living with unwanted self
  - Loss of life
  - Contrast in selves
  - Normalising experience
  - Dependency on others
  - Social relationships influence
  - Reaching desperation
  - Accessible service
  - Search for meaning
  - Language use
  - Simplifying the complex
  - Feelings of congruence and belonging
  - Sensitivity in initial stages
  - Poor awareness of service
  - Being grateful for access
  - Seeking human contact
  - Perceived burden on GPs
  - Dependency on others
  - Personal responsibility
  - Desire to come off medicine
  - Contrast of selves
  - Prolonged condition
  - Being cynical
  - Low expectations
  - Unclear identity
  - Feelings of restlessness
  - Managing uncertainty
  - Feeling forced and restricted
  - Impact of language
  - Reluctance to open up on the phone
  - Feeling isolated
  - Overcoming social norms
  - Frustrated progress
  - Search for meaning
  - Conflicted identity
  - Desire for speeded engagement
  - External input
  - Accommodating therapy into life

Struggle to be referred
Impact of scores
Intrinsic motivation
Making admissions for service

Feeling a Connection in Therapy

- Super-ordinate themes
  Service engagement as arena for learning and self-reflexivity
  The authenticated self
  Focus on therapeutic relationship
  Service engagement as congruent with self
  Coping with service anxiety
  The authenticated self
  Service as transforming self
  Self as validation
  Managing service anxiety
  Search for meaning
  Service engagement as self-reflexivity
  Focus on relationships and gained awareness

- Sub-ordinate themes
  Comparing and making admissions for service
  Seeking novelty and uniqueness
  Sensitivity in initial stages
  Gained self-awareness and clarity
  The learned self
  Confronting preconceptions of service
  Scores as validation
  Self as performance
  Captivated by therapist
  Developing shared language
  Sense of belonging
  Self in context
  Reluctance to engage and confront self
  Sensitivity in initial stages
  Overcoming service preconceptions
  Being withdrawn
  Endorsing therapist
  Contrast in selves
  Seeking recognition from others
  Scores as validation and additive therapeutic element
  Becoming service champion
  The liberated self
  Gained insight/revelation
  Search for meaning
  Service as time out from life
  Simplifying the complex
  Sensitivity in initial stages
  Poor awareness of services
  Being grateful for access
  Advocacy role
  Coping as recovery
  Contrast of selves
  Low expectations
  Unclear identity
  Managing uncertainty
  Feeling forced and restricted
  Impact of language
  Overcoming social norms
  Search for meaning
  Finding the right fit
  Longing for reflexive space
  Captivated by therapist
  Struggled to be referred
  Impact of scores
  Recovery as coping
  Advocacy role

Sense of Duty and Responsibility

- Super-ordinate themes
  Function of service
  Focus on prior and external factors
  Service engagement as congruent with self
  The will to act
  Focus on external factors
  Affinity for services
  The influence of external social relationships and self-perception
  The psychological consequences of prior experiences
  Coping with undesirable feelings in transitional care
  Focus on relationships and gained awareness

Service engagement as self-reflexivity

- Sub-ordinate themes
  - Seeking novelty and uniqueness
  - Longing for personal contact
  - Self as performance
  - Therapy as substitute to medicine
  - Duty towards service
  - Prior engagement with services
  - Gratitude and sense of duty
  - Scores as validation
  - Self as performance
  - Seeking recognition from others and service
  - Feeling valued and heard
  - Finding the right fit
  - Gaining control over agenda
  - Overcoming service preconceptions
  - Awareness of service as reassurance
  - Duty towards service
  - Indebtedness towards therapist
  - Living with unwanted self
  - Seeking recognition from others
  - Normalising experience
  - Scores as validation and additive therapeutic element
  - Becoming service champion
  - The liberated self
  - Social relationships influence
  - Reaching desperation
  - Search for meaning
  - Indebtedness towards service
  - Longing for the service
  - Feelings of congruence and belonging
  - Being grateful for access
  - Therapist as motivator and encourager
  - Seeking recognition of others
  - Personal responsibility
  - Desire to come off medicine
  - Prolonged condition
  - Extrinsic motivation
  - Managing uncertainty
  - Intrinsic determination
  - Feeling isolated
  - Overcoming social norms
  - Search for meaning
  - Finding the right fit
  - Longing for reflexive space
  - Desire for speeded engagement
  - Motivation for therapy
  - External input
  - Making tools relevant to life
  - Sense of duty
  - Intrinsic motivation

Perception of Self

Finding the Right Fit

- Super-ordinate themes
  - The consequences of engaging with other services
  - Focus on prior and external factors
  - Coping with service anxiety
  - Focus on external factors
  - Managing service anxiety
  - The influence of external social relationships and self-perception
  - The psychological consequences of prior experiences
  - Service engagement as self-reflexivity

- Sub-ordinate themes
  - Constraint of other services
  - Coping with loss of CAMHS
  - Comparing and making admissions for service
  - Seeking novelty and uniqueness
  - Longing for personal contact
  - Self in context
  - Therapy as substitute to medicine
  - Duty towards service
  - Dissatisfaction with health services
  - Prior engagement with services
  - Concern for GPs
  - Confronting preconceptions of service
  - Feeling valued and heard
  - Finding the right fit
  - Overcoming service preconceptions
  - Fear of being seen
  - Indebtedness towards therapist
  - Being withdrawn
  - Living with unwanted self
  - Reaching desperation
  - Accessible service
  - Search for meaning
  - Indebtedness towards service
  - Feelings of congruence and belonging
  - Sensitivity in initial stages
  - Poor awareness of services
  - Being grateful for access
  - Feeling valued and heard
  - Perceived burden on GPs
  - Desire to come of medicine
  - Contrast of selves
  - Prolonged condition
  - Being cynical
  - Extrinsic motivation
  - Low expectations
  - Reluctance to open up on the phone
  - Feeling isolated
  - Frustrated progress
  - Search for meaning
  - Finding the right fit
  - Conflicted identity
  - Desire for speeded engagement
  - Struggle to be referred
  - Making admissions for service

How the Service Sees Me: Including Challenges to Identity and the Role of Language

- Super-ordinate themes
  - Service engagement as arena for learning and self-reflexivity
  - The reserved self
  - Function of service
  - Service engagement as congruent with self
  - Coping with service anxiety
  - Longing for safety in the service
  - Affinity for service
  - Engagement as intelligible
  - Affinity for services
  - Self beyond therapy
  - Search for meaning
  - Service engagement as self-reflexivity
  - Affinity for services

- Sub-ordinate themes
  - Comparing and making admissions for service
  - Gained self-awareness and clarity
  - Self in context
  - Reluctance to voice concerns
  - The role of language
  - Gratitude and sense of duty
  - Confronting preconceptions of service
  - Scores as validation

Self as performance
Captivated by therapist
Feeling valued and heard
Service as safety net
Sense of belonging
Gaining control over agenda
Self in context
Overcoming service preconceptions
Materials as safety net
Finding stability in chaotic lifestyle
Awareness of service as reassurance
Service as safe space
Endorsing therapist
Contrast in selves
Scores as validation and additive therapeutic element
Longing for follow-up
Becoming service champion
Seeking recognition from others
Accessible service
Materials as validation
Longing for the service
Vulnerable to forgetting
Being grateful for access
Service as safety net
Advocacy role
Coping as recovery
Contrast of selves
Managing uncertainty
Impact of language
Reluctance to open up on the phone
Scores and change as validation
Making tools relevant to life
Recovery as coping
Sense of duty
Advocacy role

Self beyond therapy
Impact on life
Affinity for services

- Sub-ordinate themes

The learned self
Developing new skill set
Duty towards service
Gratitude and sense of duty
Concern for GPs
Confronting preconceptions of service
Self as performance
Seeking recognition from others and service
Being seen
Overcoming service preconceptions
Awareness of service as reassurance
Duty towards service
Endorsing therapist
Contrast in selves
Seeking recognition from others
Normalising experience
Becoming service champion
The liberated self
Social relationships influence
Idealising service
Longing for the service
Being grateful for access
Seeking recognition of others
Advocacy role
Contrast of selves
Low expectations
Longing for reflexive space
External input
Sense of duty
Advocacy role

The Enabled Self: Validating Recovery

- Super-ordinate themes

Service engagement as arena for learning and self-reflexivity
The authenticated self
Affinity for service
The authenticated self
Service as transforming self
Affinity for services

Outside Factors

The Role of Others

- Super-ordinate themes
  The reserved self
  Focus on prior and external factors
  Focus on therapeutic relationship
  Focus on external factors
  Focus on therapeutic relationship
  The influence of external social relationships and self-perception
  Coping with undesirable feelings in transitional care
  Focus on relationships and gained awareness

- Sub-ordinate themes
  Coping with loss of CAMHS
  Reluctance to voice concerns
  Longing for personal contact
  Impact of social norms and pressures
  Duty towards service
  The role of language
  Detrimental influence of relationships
  Concern for GPs
  Seeking recognition from others and service
  Being seen
  Apprehensive of over the phone therapy
  Captivated by therapist
  Feeling valued and heard
  Seeking human contact
  Developing shared language
  Indebtedness towards therapist
  Endorsing therapist
  Being withdrawn
  Seeking recognition from others
  Dependency on others
  Social relationships influence
  Seeking recognition from others
  Search for meaning
  Language Use
  Attachment and kinship to therapist
  Feeling valued and heard
  Therapist as motivator and encourager
  Seeking human contact
  Perceived burden on GPs
  Dependency on others
  Seeking recognition of others
  Personal responsibility
  Extrinsic motivation
  Reluctance to open up on the phone
  Feeling isolated
  Overcoming social norms
  External input
  Captivated by therapist
  Accommodating therapy into life
  Struggle to be referred

The Necessary Journey

- Super-ordinate themes
  - The consequences of engaging with other services
  - Focus on prior and external factors
  - Service engagement as congruent with self
  - Coping with service anxiety
  - Focus on external factors
  - Managing service anxiety
  - The influence of external social relationships and self-perception
  - The psychological consequences of prior experiences
  - Coping with undesirable feelings in transitional care
  - Impact on life

- Sub-ordinate themes
  - Constraint of other services
  - Comparing and making admissions for service
  - Longing for personal contact
  - Sensitivity in initial stages
  - Self in context
  - Dissatisfaction with health services
  - Confronting preconceptions of service
  - Apprehensive of over the phone therapy
  - Self in context
  - Sensitivity in initial stages
  - Overcoming service preconceptions
  - Fear of being seen
  - Longing for follow-up
  - The liberated self
  - Dependency on others
  - Social relationships influence
  - Accessible service
  - Service as time out from life
  - Sensitivity in initial stages
  - Poor awareness of services
  - Being grateful for access
  - Seeking human contact
  - Dependency on others
  - Feelings of restlessness
  - Feeling forced and restricted
  - Reluctance to open up on the phone
  - Intrinsic determination
  - Frustrated progress
  - Desire for speeded engagement
  - Accommodating therapy into life
  - Intrinsic motivation

11.16 Short Extract from Reflective Diary

11.16.1 Practitioner Group: **“Kevin”**

Kevin was particularly excited to talk about his experiences of the IAPT programme, including its implementation and provision of services. He was very welcoming and composed, with us both building rapport quickly. I had gathered in the email correspondence that Kevin was a very approachable person and I was therefore keen to meet him and discuss my thesis. Before the interview began he took a long look at the participant information sheet, appearing quite pensive about what the study entailed. After reading it over with some thought he was happy to sign the consent form and I relayed other information regarding his right to withdraw.

I noticed that many of Kevin’s responses were very clear and long, with very little repetition or stopping for pauses, if not only to catch his breath. It was not like he was frantic about getting his voice across, as much of how he said things was very calm and composed. I was very impressed with his level of insight and some of the answers he replied with. Likewise his responses required very little prompting from me, although we had a good discussion at intermittent times. For him it seemed that the implementation of IAPT was very much a step in the right direction, using the best available knowledge to create maximum benefit. The whole thing was incredibly beneficial for everyone, with him appearing generally in awe of the efforts and achievements of the programme. No negative experiences could really be drawn from his time with IAPT, only with things beyond the boundaries of the service, such as the wider NHS context. At times Kevin seemed to take on a role almost similar to that of a salesman, with him advertising and utilising the choice offerings to ensure the client was not coerced into a type of treatment they might disliked, very much leaving it up to them.

Perhaps his calm came from the fact they are very successful services, or it is according to him anyway. Overall he came across as very optimistic and grateful for the opportunity to be reflecting and feeding back in this way. I gathered that much of this stemmed from a time before IAPT where provision appeared to be a little bit chaotic, or that’s how it was portrayed by him. The end was wrapped up shortly which was a shame as I enjoyed my time discussing his experiences with him. This was due to the demands of his job and I think he had a meeting shortly after meeting with me. That being said, none of this impacted on his desire to make sure that what he wanted to say was said.

11.16.2 Client Group: **“Sarah”**

My first impressions of Sarah were one of admiration and appreciation; perhaps because of the poor recruitment my study is currently suffering. Either way, she had made it to the interview right on time and was eager to participate and let me know her experiences from start to finish. She sat down and after being introduced and discussing the study materials; she almost immediately shot off talking about her time with the service. I noticed that some of her replies were diverting from the focus of the interview, with her opting to tell me all about her condition, not necessarily about her experiences with the service. Nevertheless, I think I got her back on track with a few gentle prompts and reminders and she didn’t seem perturbed by these.

I gathered that we hit it off fairly well and almost immediately, with her not seemingly holding anything back with regard to her experiences. She spoke at one point as if to say, you’re probably asking the wrong person here, making me think that she was expecting me to see her as a vulnerable person with a negative experience of the service. I responded stating this was not the case, I had no prior agenda, and her experiences were greatly valued. There may have been a power imbalance perceived at one point, although I don’t think it lasted very long as I was able to pick up on it fairly quickly and rectify this.

I noticed that much of Sarah’s experiences of engaging with a service and accessing it was greatly influenced and may be even determined by her relationship to her family, particularly her husband. Prior to accessing the service her experiences were characterised by denial, fearing to confront her issues head on. The point of access was a particularly emotional time because of this and she even considered what the service and therapist thought of her quite a bit. Although these experiences were described with hindsight as being overwhelming, in the interview these emotions did not surface. Instead she seemed very strong, enabled and confident to respond, may be even singing the praises of her engagement in therapy. For Sarah engaging with therapy was a gradual revelation and process of self-discovery. She was extremely positive about the whole thing and I sensed was eager to tell me this because of her positive experience.